



**HEALTH CARE REFORM : PROVISIONS IMPACTING CHILDREN'S HOSPITALS
FINAL BILL (INCLUDING RECONCILIATION)**

IMPACT OF LEGISLATION	
Cost	Reduces the federal deficit by \$143 billion over the 2010-2019 time period (\$124 billion for health reform provisions and \$19 billion for education provisions), according to the Congressional Budget and the Joint Committee on Taxation. Not included are at least \$15 billion in discretionary costs (e.g., IRS and US HHS implementation costs and authorizations made for specific amounts that require appropriations).
Number of Insured	Reduces the number of nonelderly uninsured by 32 million, leaving 23 million uninsured (of which about one-third are undocumented immigrants). The share of legal nonelderly residents with insurance would rise from 83% currently to about 95% by 2019.
INSURANCE REFORM	
Individual Mandate	Requires citizens and legal residents to have coverage, enforced through tax penalties (effective 2014). Penalties begin at \$95 in 2014 and increase to \$695 by 2016 (or up to 2.5% of income), with exemptions for persons with income below the tax threshold (\$9,350 for singles and \$18,700 for couples) or for lack of access to affordable coverage. Penalties for children are half of the adult amounts.
Health Insurance Exchanges	Creates state-based exchanges for individuals to purchase coverage and separate exchanges for small businesses (up to 100 employees) to purchase coverage in 2014. Administered by a governmental entity or nonprofit organization, with funding available to states within 1 year of enactment. States may allow larger businesses to purchase exchange coverage beginning in 2017. State Medicaid and CHIP agencies may determine eligibility for subsidies.
Exchange Plan Benefits	Creates an essential benefits package covering at least 60% of the actuarial value of covered benefits. Outlines 4 plan tiers, with varied benefits and actuarial values, and a separate catastrophic plan for young adults. Requires basic plan to include preventive and wellness services, as well as pediatric services (including oral and vision care). Mental health and substance use disorder services must also be provided. Insurers must report to the Secretary on pediatric quality measures.
Federal Coverage Option	Requires the federal Office of Personnel Management to contract with at least two multi-state qualified health plans through the exchanges, effective 2014. Provider rates would be negotiated.
Subsidies	Provides tax credits for premiums and cost-sharing to persons up to 400% of the Federal Poverty Level (FPL) (\$88,000 for a family of 4) to buy insurance through the exchanges beginning in 2014. Offers credits on a sliding scale with premium contributions up to 9.5% of income at 400% FPL. Extends cost-sharing credits on a sliding scale to persons up to 400% FPL.
Immigrant Provisions	Requires Legal Permanent Residents (LPRs) to meet the individual mandate. LPRs may receive subsidies. Undocumented persons may not receive subsidies or purchase exchange products.
Employer Requirement	Requires employers with over 50 workers to offer coverage or pay a penalty if any employee receives subsidized exchange coverage (effective 1/1/14). Penalties equal \$2,000 per full-time worker, with the first 30 employees exempted.
Small Employers	Provides tax credits to small employers for insurance worth up to 35% of amounts paid for employee health coverage (phases out at 25 employees or \$50,000 in average wages), effective 2010 through 2013. The maximum amount increases to 50% in years 2014 and 2015.
Insurance Coverage	Prohibits coverage denial to children for pre-existing conditions, lifetime caps on coverage, unreasonable annual limits on new plans, and rescission of coverage when people get sick, effective 6 months after enactment. Requires health plans to provide rebates related to medical loss ratios beginning in 2011 (for non-claims costs exceeding 15% for large group market plans and 20% for small and individual market plans). Prohibits annual limits on coverage for all plans, effective 2014. By 2014, requires guarantee issue and renewability and allows rating variation based only on age (limited to 3:1 ratio), premium rating area, family composition and tobacco use (limited to 1.5:1).
Preventive Services	Requires health plans to provide (without cost-sharing) evidence-based items or services rated "A" or "B" by the U.S. Preventive Services Task Force; immunizations recommended by the CDC; and, for children, preventive care and screenings supported by guidelines from the Health Resources



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And Services Administration (effective within 6 months of enactment).



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INSURANCE REFORM (CONTINUED)	
Policy Excise Tax	Imposes a 40% tax on policy issuers beginning in 2018 for coverage values exceeding \$10,200 for single policies and \$27,500 for family policies, with several adjustments (e.g., gender composition and dental coverage). Makes exceptions for retirees and high-risk professions.
Short-term Initiatives	Creates a temporary reinsurance program for employers providing coverage to retirees over age 55 who are not eligible for Medicare and an interim high-risk pool for individuals without insurance due to pre-existing conditions (both effective in 2010).
MEDICAID	
Eligibility Expansion	Expands coverage to nonelderly individuals up to 133% FPL (\$29,000 for a family of 4), effective 2014. Provides federal funds at 100% in 2014, 2015 and 2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% in subsequent years (for the newly eligible). States that previously expanded eligibility to childless adults receive enhanced funding starting at 50% in 2014, rising to 90% by 2020. Requires states to provide coverage to individuals who have been in foster care at least 6 months up to age 25 (effective 1/1/14).
Income Criteria	Requires states to use modified adjusted gross income in determining eligibility and prohibits asset tests. In lieu of income disregards, states will apply an income deduction allowance of 5% (effectively raising the income limit to 138% FPL).
Maintenance of Effort	Requires states to maintain eligibility standards, methodologies and procedures from date of enactment through 9/30/19 for children and until the exchange is fully operational for adults. Between 1/11/11 and 12/31/13, states with budget deficits may reduce eligibility for nonpregnant, nondisabled, nonwaiver persons with income exceeding 133% FPL.
Preventive Services	Provides a one percentage point increase in the FMAP for preventive services and recommended immunizations (effective 1/1/11).
Benefits	Allows children to receive hospice services without waiving rights for treatment of terminal illness. Requires states to cover tobacco cessation services for pregnant women (effective 2010).
Provider Rates	Requires states to pay at least 100% of Medicare rates from 1/1/13 to 1/1/15 for evaluation and management services, as well as services related to immunization administration for vaccines and toxoids, furnished by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine. Provides 100% federal funds for the difference in payment above the state's rate for these services in place on 1/1/09.
Disproportionate Share Hospital (DSH) Funding	Reduces DSH funding by a total of \$18.1 billion: 2014: \$500 million; 2015: \$600 million; 2016: \$600 million; 2017: \$1.8 billion; 2018: \$5 billion; 2019: \$5.6 billion; and 2020: \$4 billion. The largest DSH cuts will be imposed on states with the lowest percentage of uninsured individuals and states that do not target DSH funds to hospitals with high volumes of Medicaid inpatients and uncompensated care.
Prescription Drugs	Increases the drug rebate to 23.2% of brand-name drugs and 13% of the average price for other select drugs and extends the rebate to managed-care programs (with gain directed to the federal government). Permanently extends the 340B discount program to children's hospitals, but exempts orphan drugs (effective 2010).
Payment Reform	Creates a Center for Medicare and Medicaid Innovation by 1/1/11 to pursue payment and delivery system reform, while improving quality and efficiency. Creates new demonstration project to make bundled payments for episodes of care that include hospitalizations (effective 1/1/12 through 12/31/16).
Fraud and Abuse	Creates a Center for Program integrity (within CMS). Authorizes more stringent screening processes for provider enrollment, based on the level of risk. Requires providers to return overpayments within 60 days (or be subject to liability under the False Claims Act) and to have compliance plans.



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CHIP	
Eligibility	Extends authorization for CHIP through 2015. If federal CHIP allotments are inadequate, states must assure coverage is available through the exchange. Allows children of state and local public employees to enroll if the state's premiums and cost-sharing exceed 5% of family income and if premium contributions have not declined below 1997 levels (adjusted for inflation).
Income Criteria	Requires states to use modified adjusted gross income in determining eligibility, effective 1/1/14. Requires states to enroll children into CHIP who are ineligible for Medicaid due to elimination of income disregards.
Maintenance of Effort	Requires states to maintain CHIP eligibility standards, methodologies and procedures from enactment through 9/30/19.
Enhanced FMAP	Increases each state's federal match rate by 23 percentage points, effective 10/1/15 to 10/1/18.
Benefits	Requires the Secretary to study benefits and cost-sharing protections and certify exchange plans that are comparable to CHIP by 4/1/15.
QUALITY INITIATIVES	
Hospital-acquired Conditions	Prohibits Medicaid payment for hospital-acquired conditions, effective 7/1/11.
AHRQ Projects	Expands AHRQ demonstration projects through Pediatric Quality Improvement Collaboratives and Learning Networks (effective 2010). Requires AHRQ to implement a national application of Intensive Care Unit Improvement projects relating to adult, pediatric and neonatal patients.
Comparative Effectiveness	Creates a nonprofit Patient-Centered Outcomes Research Institute in 2010 to conduct research comparing the clinical effectiveness of medical treatments.
Innovation Center	Creates a Center for Medicare and Medicaid Innovation to evaluate and implement payment structures and methodologies that improve coordination, quality and efficiency of services (effective 1/1/11).
Medical Home	Offers a Medicaid state option to provide coordinated care through a health home for individuals with chronic conditions. Makes available up to \$25 million for state planning grants and provides enhanced FMAP (90%) for medical assistance for 2 years (effective 1/1/11).
Accountable Care Organizations	Creates a five-year Medicaid pilot program allowing pediatric providers to share in savings through care coordination and quality initiatives (beginning in 2012).
Global Payments	Authorizes Medicaid demonstrations for up to 5 states for safety net hospital systems or networks moving from fee-for-service payment (effective 2010).
Bundled Payments	Authorizes Medicaid demonstrations for up to 8 states to evaluate integrated care for episodes of care that include hospitalization (effective 2012).
AVAILABILITY OF HEALTH PROFESSIONALS	
Graduate Medical Education	Redistributes 65% of vacant Medicare residency positions in favor of primary care and general surgery, beginning in 2011. Allows hospitals to apply for up to 20 additional primary care residency slots. Promotes outpatient training settings.
Incentive Programs	Creates several incentive programs, including a loan repayment program for pediatric subspecialists, specialists and child and adolescent mental and behavioral health care providers (beginning in 2010).
National Commission	Creates a National Health Care Workforce Commission to review workforce supply and evaluate education and training activities. Requires member appointment by 9/30/10 and report by 10/1/11.



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PUBLIC HEALTH	
Public Health Investment	Creates a Prevention and Public Health Fund totaling \$15 billion over 10 years to address public health issues (effective 2010). Provides competitive grants to states and local entities to reduce chronic disease, address health disparities and develop stronger evidence-based strategies.
Epidemiology and Lab Capacity	Provides annual grants totaling \$190 million to state, local and tribal entities to improve surveillance and response to infectious diseases and other public health conditions (effective 2010 to 2013).
Home Visitation	Creates a Maternal, Infant and Early Childhood Home Visitation program funded at \$1.5 billion for 2010 through 2014 to improve health, childhood injury prevention, school readiness and juvenile delinquency.
Obesity	Requires chain restaurants to put caloric content and nutritional information on menus and vending machine operators to post caloric content (regulations to be issued within 1 year of enactment).
MISCELLANEOUS PROVISIONS	
Charitable Hospitals	Requires hospitals to conduct a community needs assessment at least every 3 years (beginning 2 years after enactment) to maintain tax exempt status. Requires such hospitals to adopt a strategy for implementation, a financial assistance policy, and related billing and collection practices. Requires hospitals to make public a list of standard charges and set a charge limit based on the lowest amount billed to insured patients. Imposes a tax of \$50,000 for failure to meet requirements.
Medical Malpractice	Provides 5-year demonstration grants to states to develop alternative medical liability laws that improve current tort litigation systems (effective in 2011).