

## Health care reform becomes law

**ON** March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590). One week later, he signed the Health Care and Education Reconciliation Act of 2010 (H.R. 4972). Together, these laws represent the most sweeping health care reforms in U.S. history. The laws dramatically expand coverage and provide important consumer protections. They also expand Medicaid and make numerous Medicare payment and policy changes. Finally, they invest billions of dollars in prevention and wellness programs, boost physician, nurse and direct care worker education, and significantly increase the government's capacity to fight fraud and abuse.

This article describes the most important reforms for individuals with brain injury and explains the critical role played by the Brain Injury Association of America (BIAA) and its Business & Professional Council in the legislative process. A detailed analysis of H.R. 3590, as amended, is available from the BIAA's Web site at [www.biausa.org](http://www.biausa.org).

### **Expanded coverage**

The U.S. Census Bureau estimates 46 million Americans are uninsured. The newly enacted laws seek to reduce that number through individual, employer and state mandates.

Anyone who has insurance can keep it, assuming premium payments are made for private plans and eligibility requirements are met for Medicare and Medicaid. Those without health insurance must get it by 2014 or face a penalty. The penalty is projected to be \$95 per person in 2014, \$325/person in 2015 and \$695/person thereafter. The penalty will not be assessed on religious objectors, illegal immigrants or people who are incarcerated. Exemptions are also available based on financial hardship. Individuals and families with incomes of 133-400 percent of the federal poverty level will be eligible for tax credits and may receive direct financial assistance for premium payments. Some individuals and families may be eligible for special limits on cost-sharing and out-of-pocket expenses too.

The new laws require employers to offer affordable coverage to their workers by 2014. Under certain conditions, companies with more than 50 full-time equivalent employees



will be penalized \$2,000 per employee for failing to provide coverage. Companies with less than 25 full-time equivalent employees will be eligible for tax credits when they provide coverage.

To make health insurance more affordable, the laws require each state to create a Health Benefit Exchange by 2014. The exchange will be a virtual marketplace in which private insurers like Aetna, Blue Cross/Blue Shield, UnitedHealth Care and others may offer individual and small group policies. The exchanges are authorized to offer large group plans if allowed by the state. The federal government is required to offer at least two multi-state plans in each exchange, and at least one must be provided by a non-profit organization.

Exchanges will begin with grants from the federal government, but must be self-sustaining by 2015. The federal government will establish an exchange in any state that fails to do so by 2014. States may seek approval from the U.S. Department of Health and Human Services (DHHS) for voluntary interstate and regional exchanges as well as subsidiary exchanges. States will have the flexibility to offer certain health plans to eligible individuals in lieu of offering those individuals insurance through an exchange. Eligible individuals would have income of 133-200 percent of the federal poverty level and would be ineligible for Medicaid, Medicare or an affordable employer-sponsored plan. Nothing in the reform package prevents an individual from obtaining coverage outside of a state exchange, but consumer protections and insurance regulations, discussed below, will

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still apply to non-exchange plans.

### **Essential benefits**

Health insurance companies that sell policies to individuals or small groups will be required to offer coverage that meets or exceeds the essential benefits package [at right]. As prescribed by the new laws, the benefits package must include key categories of health services such as hospitalization, physician services, prescription drugs, rehabilitative and habilitative services and devices, vision and oral pediatric services, mental health services and chronic disease management services, among others.

The DHHS secretary will develop standard definitions for the benefits as well as other terms used in insurance coverage. The benefits cannot be unduly weighted toward any one key category and cannot discriminate against individuals because of age, disability or life expectancy. Other rules will apply too, such as limits on annual deductibles (\$2,000 for individuals and \$4,000 for families) and out-of-pocket expenses (\$5,950 for individuals and \$11,900 for families).

The rules of the essential benefits package take effect in 2014 and apply to insurers that offer individual and small group policies both inside and outside of the state exchanges. The essential benefits package rules do not apply to self-insured health plans organized under the Employee Retirement Income Security Act (ERISA), which is regulated by the U.S. Department of Labor.

### **Consumer protections and insurer regulations**

Currently, state insurance commissions are responsible for setting the rules and regulations for health insurers in their states. Under the new laws, the commissions will continue to do so except that certain consumer protections and nondiscrimination rules will apply nationwide as follows:

**Therapy limits** — Effective March 23, 2010, the HHS secretary is prevented from establishing regulations that limit access to therapies and health care services based on a variety of factors.

**High risk pool** — Effective June 21, 2010, a special insurance program will be established for individuals who have been uninsured for at least six months and have a pre-existing condition. The temporary program allows premium rating based on age but not health status, and there are maximum cost-sharing limits. The temporary program is in effect until 2014, when the exchanges are established.

**Policy cancellation** — Effective Sept. 23, 2010, all plans will

### **Essential Benefits Package — The basics** (effective 2014)

- Hospitalization Coverage
- Physician Services
- Prescription Drugs
- Rehabilitative and Habilitative Services & Devices
- Vision & Oral Pediatric Services
- Mental Health Services
- Chronic Disease Management
- \$2,000 annual limit on deductible for individuals
- \$4,000 annual limit on deductible for families
- \$5,950 annual limit on out-of-pocket expenses for individuals
- \$11,900 annual limit on out-of-pocket expenses for families

be prohibited from cancelling a covered individual, except in the case of intentional misrepresentation or other fraudulent acts.

**Preventive services** — Effective Sept. 23, 2010, all plans will be required to cover certain preventive services and immunizations without any cost-sharing.

**Pre-existing conditions** — Effective Sept. 23, 2010, insurance companies will be prohibited from imposing pre-existing condition exclusions in individual and small group plans for children under age 19. Effective 2014, the pre-existing conditions rule applies to adults too.

**Refunds for non-claim costs** — Effective Sept. 23, 2010, insurers must refund each enrollee for non-claims costs that exceed 20 percent in the group market and 15 percent in the individual market. Health insurance companies will be required to report the percentage of premiums spent on clinical services (e.g., medical loss ratios), quality, and all other non-claims costs.

**Appeals** — Effective Sept. 23, 2010, insurers must implement an effective internal appeals process for coverage determinations and claims and comply with any applicable state external review process. For states without an external review process or for self-insured plans, insurers must implement an external review process meeting minimum standards established by the HHS secretary.

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**Lifetime and annual limits** — All plans will be prohibited from establishing lifetime limits on the dollar value of essential benefits, effective 2014. Until then, there will be restrictions on the annual limits set for group plans and non-grandfathered individual plans for plan years beginning Sept. 23, 2010.

**Premium rates** — Effective 2014, premiums for individual and small group plans will vary based only on family structure, geography, age, tobacco use and the actuarial value of the benefit.

**Guaranteed issue** — Effective 2014, insurance issuers will be required to accept every employer and individual who applies for coverage during annual and special enrollment periods.

**Guaranteed renewal** — Effective 2014, insurance issuers will be required to renew individual and small group plans.

**Health status discrimination** — Effective 2014, insurers will be prohibited from discriminating against individual plan participants due to health status, medical history or condition,

### **BIAA's role in health care reform**

The Brain Injury Association of America has shaped every piece of federal legislation affecting individuals with brain injury. The newly enacted health care reform laws are no exception.

In 2008, BIAA formed the Brain Injury Business & Professional Council to increase access to care, improve patient outcomes, and promote long-term viability of the brain injury rehabilitation industry. At the start of 2009, BIAA and the Business Council engaged the lobbying firm of Powers, Pyles, Sutter & Verville, P.C. (PPSV) to assist staff and volunteer leaders in formulating and implementing a strategy for health care reform.

Advocacy efforts began with a Congressional Fly-in held on Feb. 26, 2009. Fly-in participants circulated BIAA's brochure entitled, "Are You Covered?" to Capitol Hill staffers to demonstrate the incidence, prevalence, treatment options and value of rehabilitation for individuals with brain injury. Shortly thereafter, BIAA and PPSV staff worked with Council leaders to write a position paper that articulated a number of guiding principles for health reform. In short, the guiding principles are:

*Brain injury is the start of a lifelong disease process requiring access to a full continuum of medically necessary treatment, including rehabilitation, furnished by accredited programs in the most appropriate treatment setting as determined in accordance with the choices and aspirations of the patient and family in concert with an interdisciplinary team of qualified and specialized clinicians.*

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claims experience, genetic information, disability, evidence of insurability, or any other factor determined by HHS.

**Provider discrimination** — Effective 2014, insurers are prohibited from discriminating against health care providers by denying them participation in a plan if the provider acts within the scope of their professional license and applicable state laws. This provision does not require a group health plan or health insurance issuer to contract with "any willing provider," even if the provider agrees to abide by the terms and conditions for participation established by the plan or issuer.

**Waiting periods** — Effective 2014, waiting periods in excess of 90 days are prohibited for individual and small group plans.

### **Medicaid and Medicare changes**

The new laws prescribe several changes in state Medicaid programs. For example, effective April 1, 2010, states may provide more types of home- and community-based services (HCBS) to individuals with higher levels of need under the state plan, rather than through a waiver. States may also extend full Medicaid benefits to individuals receiving HCBS under a state plan amendment.

Starting Oct. 1, 2011, states will be incentivized to shift Medicaid beneficiaries out of nursing homes and into HCBS. States will have the option of enrolling Medicaid beneficiaries with chronic conditions into team-based comprehensive care programs. Also beginning in 2011, a new optional Medicaid benefit will be available to states to provide community-based attendant services and supports to Medicaid beneficiaries who would otherwise require the level of care offered in a facility such as a nursing home.

Beginning in 2013, states will be incentivized to cover clinical preventive services and immunizations for adults and will be required to provide premium assistance and wrap-around benefits to Medicaid beneficiaries who are offered health insurance through an employer. Also starting in 2013, payments to primary care physicians who treat Medicaid beneficiaries will equal Medicare rates.

As of 2014, the minimum Medicaid income eligibility will be lowered to 133 percent of the federal poverty level. However, a new five percent income disregard will be applied to all beneficiaries so Medicaid eligibility will actually become 138 percent of the federal poverty level. Also starting in 2014, certain prescription drugs, such as those for smoking cessation, will be removed from the excluded list.

Under the new laws, several pilot programs, known as demonstrations, will be created. One demonstration involves bundling hospital fees and physician services into a single

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payment; another revises the payment structure for “safety net” hospitals; a third involves recognizing certain pediatric providers as Accountable Care Organizations, and a fourth requires states to reimburse hospitals and institutions when stabilizing patients with emergency psychiatric conditions. Several demonstrations are targeted to nursing homes. All of the pilot programs begin in different years and run different lengths of time. Some programs will be conducted in eight states; others will be available in only two states. The new laws also continue the current “Money Follows the Person” demonstration through 2016 and expand the Recovery Audit Contractor program to identify Medicaid overpayments, fraud and abuse.

The new laws usher in many changes to Medicare payment policies, most of which are beyond the scope of this article. Some, however, are of specific interest to individuals with brain injury and their care providers. For example, under the new laws, hospitals will be penalized if they make frequent, avoidable medical errors. They’ll also be penalized for preventable readmissions of Medicare patients with specific conditions. On the other hand, hospitals that provide efficient care and those providing vital services in rural areas will be rewarded. Starting in 2014, long-term care hospitals, inpatient rehabilitation hospitals, hospice providers and others will be required to participate in a quality measure reporting program.

Although the reform package did not address the current physician rate problem, it did include new rules that will benefit primary care physicians who provide evaluation and management services for designated groups, those who provide psychiatric services and those in rural areas. The package also gives the HHS secretary authority to adjust fees for physician services that were previously “mis-valued” or inaccurate.

Some of the Medicare payment changes will impact post-acute care providers. For example, the exceptions process to caps on medically necessary rehabilitation therapy services will remain in place until the end of 2010, when the rules may be continued for another year. However, there are new caps on the payments home health providers can receive. There are also changes in the bidding process for durable medical equipment and in the claims forms and cost reporting requirements for hospice.

As with the Medicaid program, the new laws authorize several grant programs and demonstration projects that may impact Medicare beneficiaries. These include physician and preventive medicine training grants, support for care providers who treat a high percentage of medically underserved populations, opportunities to develop “independence at

### **Consumer protections**

- Regulations cannot limit access to therapy and services
- Special insurance programs for the uninsured with pre-existing conditions
- Policies against cancelling insurance
- Requirement for preventive services
- Must have an appeals process
- Guarantees on insurance issuance and renewal
- Prohibition of health status discrimination
- Prohibition of discriminating against providers of health care services

home” medical practices, community-based care transition programs, grants for the collection of quality and resource use data, and voluntary programs to test the feasibility of bundled payments to hospitals, physicians and post-acute providers so as to reduce costs while delivering high quality care. The bundling demonstration is set to begin on Jan. 1, 2013. If it is successful, it may be expanded starting in 2016.

As with insurers in the individual and small group markets, Medicare Advantage (MA) insurers will abide by new payment levels, administrative cost limits, and cost-sharing protections. Additionally, MA policyholders will receive annual wellness visits with no co-payment or deductible applied.

Effective Jan. 15, 2014, the reform package establishes an independent payment advisory board to recommend Medicare cost cutting proposals to Congress. The board’s recommendations would automatically take effect unless Congress passes an alternative measure that achieves the same level of savings.

### **Other key provisions**

Effective March 23, 2010, the reform package created an interagency council to establish and implement a national prevention and health promotion strategy, a commission to provide oversight for a national health key indicators system, and a \$15 billion appropriation for a Prevention and Public Health Investment Fund. The reform package also authorized grants for improvements in community health, prevention of chronic diseases, collection of health disparity data, and the development of standards to increase accessibility of diagnostic equipment. There are also programs to improve employer-based wellness practices and to study pain management.

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The new laws authorize \$50 million over five years in grants to states to evaluate alternatives to medical malpractice litigation that expedite the resolution of disputes, reduce medical errors, and improve patient safety. There's also a grant program to improve protections for seniors in long-term care facilities. Additionally, the reform package makes significant investments through grants and loan programs to attract and support primary care physicians, pediatric and geriatric specialists, nurses, mental and behavioral health professionals, direct care workers, public and allied health students. Funds will also be available for the National Health Service Corps and Community Health Centers. There are also significant sums allocated to technology improvements and for comparative effectiveness research.

### **Paying for health reform**

The projected cost of the various reforms is \$1 trillion over the next 10 years, which will be paid by a variety of taxes and penalties. The new laws levy a 40 percent excise tax on the excess amount of high-cost insurance plans above the threshold of \$10,200 for single coverage and \$27,500 for family coverage. There are special rules for high-risk groups and adjustments for age and gender. An annual fee ranging from \$2.5 billion to \$4.1 billion per year on the pharmaceutical manufacturing sector begins in 2011.

Effective 2013, non-taxable contributions to flexible spending accounts (FSAs) are capped at \$2,500 annually. A 2.3 percent tax is imposed on certain medical devices, although there are exemptions for eyeglasses, contact lenses, hearing aids, retail items, and other devices. Also in 2013, the adjusted gross income threshold for claiming the itemized deduction for medical expenses increases from 7.5 percent to 10 percent; individuals age 65 and older are not subject to the increase until 2017. Also in 2013, certain Medicare tax increases are planned. And finally, a new fee on insurers, varying from \$8 billion to \$14.3 billion per year, will be imposed beginning in 2014. ❖

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## **BIAA's role in health care reform**

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Throughout the summer, the guiding principles were distributed in high-level meetings with Congressional lawmakers and White House officials. The principles formed the backdrop for written comments submitted to each committee of jurisdiction in both chambers of Congress. Despite BIAA's broad-based advocacy effort, the original version of the Senate Finance Committee bill excluded rehabilitation, habilitation and related devices from the categories of health services in the essential benefits package.

It was only through BIAA's special negotiations with Senate Finance Committee staff and intensive lobbying with Senate Finance Committee Members that rehabilitation was added to the Patient Protection and Affordable Care Act that was signed into law in March 2010. If BIAA had been any less aggressive in its advocacy efforts, it is possible, indeed likely, that persons with brain injury who have individual and small group health plans would have no access to rehabilitation whatsoever. The importance of this achievement cannot be overstated.

While BIAA won the first skirmish in the health reform battle, there is a fight ahead with respect to obtaining favorable language under the essential benefits package and in enforcing the regulations at the federal level and on a state-by-state basis. To that end, BIAA invoked its strong working relationship with Congressman Bill Pascrell, co-chair of the Congressional Brain Injury Task Force, to twice insert language into the Congressional Record concerning the intent of the new laws for individuals with brain injury.

BIAA will continue to advocate for people with brain injury and for access to the full continuum of treatment in the coming years. In the meantime, the BIAA is deeply grateful to the members of the Business Council for the financial support and technical expertise that made the health reform victory possible and to the nationwide network of state affiliates and advocates who assist BIAA in spreading help, hope and healing to millions of people with brain injury each year. ❖

## National health care reform: What does it mean to Michigan's Auto No-Fault law?

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With the recent passing of the Patient Protection and Affordable Care and the Health Care and Education Reconciliation Act of 2010, one might ask, what will be the interplay between national health care and Michigan's Auto No-Fault Insurance program? Further, will national health care serve as a replacement for the Michigan Catastrophic Claims Association (MCCA)\*?

The short answer is not likely.

Susan Connors did an excellent job of outlining the intended effects of these two bills (see Health Care Reform Becomes Law, page 1). However, there is still much more work to do on these bills and that may change the tenor or practical application of them.

At the most basic level, these bills will eventually ensure that more Americans will have health insurance coverage. By 2014, all Americans without health care insurance must obtain insurance or pay a penalty. The penalty is projected to be \$95 per person in 2014, \$325/person in 2015 and \$695/person thereafter. In looking at the cost of insurance versus the penalty, some people may choose to pay the penalty.

These bills will also set the minimal limits of coverage in the "Essential Benefits Package." The package outlines the minimal coverage a person can expect. The complete list is outlined in the sidebar on page 2. What's important to point out is that the Department of Health and Human Services (DHHS) secretary will set these essential benefit standards. While the bills define key areas, they do not set the actual parameters. For example,

an essential benefit in the package includes rehabilitative services, however it does not outline how much rehabilitative service will be allowed. The DHHS secretary will set this standard.

In 1973, when Michigan's Auto No-Fault was enacted, we gave up certain rights to sue an at-fault party, in exchange for lifetime medical coverage for injuries sustained in a motor vehicle accident. The No-Fault law provides for a broad level of coverage for those catastrophically injured. This coverage includes "All reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery or rehabilitation." This level of accident coverage has been much broader than traditional health insurance plans, and significantly more appropriately matched to the care needs of accident victims.

The brain injury community has struggled for decades to obtain adequate benefits under traditional health plans. To date, we still struggle. The Auto No-Fault program in Michigan works — if you are injured in an automobile accident, you will receive the medical services you require as a result. Most people who have different coverage in other states cannot make this claim. Thus, as national health care is no more of a replacement for No-Fault than Blue Cross Blue Shield is today, national health care is not a replacement for the MCCA.

*\* The MCCA is the citizen's reinsurance pool for covering the costs of catastrophic accidents over \$480,000 lifetime (as of July 2010) and simply serves as an extension of the no-fault law.*