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April 5, 2010

To: Supervisor Gloria Molina, Chair
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From: William T Fujioka
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WASHINGTON, D.C. UPDATE ON HEALTH CARE REFORM

This memorandum is to update your Board on Federal health care reform legislation which has been enacted in two steps. First, on March 23, 2010, President Obama signed H.R. 3590, the 2,407 page Senate-passed health care reform, and, on March 30, 2010, the President signed H.R. 4872, a budget reconciliation bill which amended many of the Senate bill's revenue and mandatory spending provisions, including those affecting Medicaid.

It will take time to interpret and analyze the health care reform legislation. Not only is the legislation extremely complex and far reaching, but the text of current law as amended by H.R. 3590 and later amended by H.R. 4872 is not yet available in print. This is because, unlike the text of State bills, Federal bill text does not show the text of current law which is being amended. The health care reform legislation is even more complicated to read because H.R. 3590 included a few hundred pages of a Senate floor amendment that amended other sections of the bill. For example, H.R. 4872 amends the excise tax on high cost employer-sponsored health coverage in Section 9001 of H.R. 3590, which, in turn, is amended by Section 10901 of that same bill. Another complicating factor is that neither enacted bill was accompanied by conference report language explaining how the bill amends current law.

It also is noteworthy that Federal legislation is far less explicit than State bills, leaving much of a bill's interpretation and implementation to the regulatory process. This is especially true of Federal statutory language pertaining to Medicaid and Medicare. This means that the interpretation of many health reform provisions will evolve as implementing regulations and other guidance are issued.

Below is a summary of major health care reform provisions of County interest.

OVERVIEW OF HEALTH COVERAGE EXPANSIONS

The legislation would greatly expand health insurance coverage by:

- Creating new health insurance exchanges through which health insurance may be purchased with Federal subsidies (tax credits) available to individuals and families with incomes between 133% and 400% of the Federal poverty level (FPL);
- Expanding Medicaid coverage to non-disabled persons below age 65 with incomes under 133% FPL, including childless adults who currently are categorically ineligible for Medicaid; and
- Requiring individuals to have health coverage and employers of 50 or more employees to offer coverage with fiscal penalties imposed for non-compliance.

These new Federal subsidies, expanded Medicaid eligibility, and requirements on individuals and employers will take effect in 2014.

After 2014, there still will be a residual number of persons who will lack health insurance -- especially many immigrants. Undocumented immigrants are barred from receiving full-scope Medicaid benefits, Federal health subsidies, and from purchasing health insurance through the new exchanges. The current five-year prohibition on full-scope Medicaid benefits for most newly arrived legal immigrants is maintained. Lawfully present immigrants, however, are eligible to purchase health insurance through the exchange and to receive Federal subsidies.

In addition, just as under the current Medicaid and the Children's Health Insurance Program (CHIP/Healthy Families in California), all potentially eligible persons will not actually participate under either those programs. Because the new individual mandate penalties will be low relative to health insurance costs for many persons, such as for healthy young adults, private health insurance also will not be purchased by all persons. Moreover, there are some exemptions from individual mandate penalties, such as for financial hardship or objections on religious grounds. Finally, the new law restores the authority of states to reduce Medicaid eligibility beginning in 2014 for adults and on

September 30, 2019 for children. Therefore, some persons may lose Medicaid eligibility in the future.

HEALTH INSURANCE REFORMS

Health Exchange Subsidies: States are required to establish health exchanges through which individuals and small employers may obtain health insurance by 2014. Federal subsidies (refundable tax credits) will be available to lower health insurance costs for individuals with incomes between 133% and 400% FPL -- that is, to persons whose incomes are too high to qualify for Medicaid. Individuals who are eligible to receive affordable employer-sponsored insurance are not eligible for subsidies. All lawfully present immigrants are eligible to purchase private coverage through the exchange and receive Federal tax credits, including those who are ineligible for full-scope Medicaid benefits because they have been in the U.S. for less than five years. Undocumented immigrants neither are eligible to obtain health coverage through the exchange nor to receive any subsidies.

Tax credits to subsidize health insurance premium costs are calculated for eligible individuals and families with incomes between 133% and 400% FPL on a sliding scale to limit their costs to a percentage of income. For example, persons with incomes below 133% FPL will receive tax credits limiting their premium costs to 2.0% of total income. This income percentage contribution rate increases to 3.0% to 6.3% for incomes between 133% and 200% FPL, 6.3% to 8.05% for incomes 133% to 200% FPL, and 8.05% to 9.5% for incomes between 300% and 400% FPL. There also would be a sliding scale of reduced out-of-pocket limits and cost-sharing subsidies for individuals and families with incomes below 400% FPL.

State Option to Cover Persons Between 133% and 200% FPL: States are given a new option to establish a health insurance plan to cover persons with incomes above Medicaid eligibility, but below 200% FPL, beginning in 2014. The Federal government would be required to provide a participating state with an amount equal to 85% of the amount that otherwise would have been spent on Federal health exchange subsidies for such persons.

Individual Mandate: All legal residents with limited exemptions (e.g., financial hardship and religious objections) will be required to have health coverage beginning in 2014. Those without coverage must pay a tax penalty of the greater of $95 a year (up to a maximum of $385 for a family) or 1% of taxable income in 2014; $325 a year (up to a maximum of $975 for a family) or 2% of income in 2015; and $695 a year (up to a maximum of $2,085 for a family) or 2.5% of income in 2016 with the $695 amount, adjusted in future years for inflation.

Employer Mandate: Employers with 50 or more full-time employees must offer health coverage to avoid a penalty fee of $2,000 per full-time employee (FTE) that would be imposed if at least one FTE were to receive a premium tax credit. The first 30 FTEs are excluded in calculating the penalty, which means that an employer with 50 FTEs would face a penalty of $40,000 (20 x $2,000). This requirement takes effect in 2014.

Temporary Reinsurance Program for Early Retirees: Within 90 days of the date of an enactment, a $5 billion temporary reinsurance program is to be established to reimburse participating employment-based plans (including state and local government plans) for part of the cost of providing retiree health benefits to retirees who are age 55 or older and who are not eligible for Medicare and their spouses, surviving spouses, and dependents. Federal reimbursement would cover 80% of a claim submitted for an early retiree or eligible family member that exceeds $15,000, but not greater than $90,000, in the first year. These dollar amounts will be adjusted annually, based on the medical care component of the Consumer Price Index, rounded to the nearest $1,000. This program will end by January 1, 2014, or earlier if the entire $5 billion appropriation is exhausted. The County's retiree health plans would be eligible to receive reimbursement under this program.

Other health insurance reforms which take effect this year include:

- Creates a temporary high-risk health insurance pool to make health insurance available to individuals with pre-existing medical conditions;
- Prohibits health plans from denying coverage to children with pre-existing medical conditions (note: this prohibition will apply to adults in 2014);
- Prohibits health plans from dropping persons from coverage when they get sick and from placing lifetime caps on coverage (note: the use of annual limits would be restricted by regulation until 2014 when they will be eliminated);
- Prohibits new group health plans from establishing eligibility rules for health coverage that have the effect of discriminating in favor of higher wage employees;
- Requires dependent coverage for children up to age 26 under all plans and that new plans cover preventive services with no co-payments and exemptions from deductibles; and
- Offers tax credits of up to 35% of premiums to small businesses to make employee coverage more affordable.

In addition, the bill establishes the new Community Living Assistance Services and Supports (CLASS) Program in 2011, which is a voluntary, self-funded insurance program through which individuals may receive services that will enable them to live in the community as an alternative to nursing homes and other institutional long-term care.

MEDICAID PROVISIONS

Medicaid Eligibility Expansion: Effective immediately, states are provided the option of covering childless adults, who currently are categorically ineligible, up to 133% FPL with the Federal match rate ("FMAP") at the current law rate, which would be 50% for California after the American Recovery and Reinvestment Act's (ARRA) temporary FMAP increase expires.

Effective in 2014, Medicaid eligibility for all parents, children age 6 or older, and childless adults will increase to 133% FPL. However, current immigrant restrictions are maintained, which means that undocumented immigrants, lawful temporary residents, and most lawful permanent residents who have been in the United States under five years will continue to be eligible only for emergency services.

A new modified adjusted gross income (MAGI) definition of income, which is based on tax code definitions, will be used to determine eligibility for not only health exchange subsidies, but also the eligibility of non-disabled and non-elderly persons for Medicaid without any asset or resource tests. Current income disregards for determining Medicaid eligibility also are replaced by a 5% income disregard. Based on 2010 Federal poverty guidelines, an individual with an income equal to 133% FPL would be able to disregard (deduct) $60 a month in income, which is less than the $90 earned income disregard in California where Medicaid applicants also are allowed to deduct $200 a month in child care expenses, $50 a month in child support collections, and the full amount of child support payments. This new definition of income makes it extremely difficult to estimate the impacts of the Medicaid eligibility expansions – especially because the MAGI definition will not apply to medically needy individuals or persons who qualify for Medicaid through another program, such as foster care or Supplemental Security Income (SSI). It is not uncommon for families to have individual members with varying Medicaid eligibility (e.g., an eligible child, one parent on SSI, and another ineligible child or parent).

An enhanced FMAP of 100% in 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in subsequent years would be provided to all states for medical assistance provided to newly Medicaid eligible individuals. States will continue to be paid at the regular FMAP (50% for California) for Medicaid recipients who meet current Medicaid eligibility requirements. Medicaid administrative costs, including for newly Medicaid eligible individuals, however, would continue to be reimbursed at the current 50% rate.

In addition, effective in 2014, all persons who were in foster care and receiving Medicaid at age 18 (or at an older age as elected by a state) will be eligible for Medicaid up to age 26.

Option for Certain Medicaid-Eligible Individuals to Enroll in Health Exchange: States are required to provide non-pregnant, non-elderly adults whose family income is between 100% and 133% FPL and who is eligible to receive exchange subsidies to enroll for themselves (or their family if applicable) in an exchange plan in lieu of Medicaid. Adults who exercise this option waive their eligibility for Medicaid services and will not receive any Medicaid assistance for any health insurance premiums or cost-sharing costs. However, states must ensure that children will continue to receive all Medicaid benefits to which they are entitled and offset any premium and health-sharing costs that exceed the allowable amounts under Medicaid.

Local Government Share of Medicaid Costs: States are prohibited from requiring local governments to incur a percentage share of non-federal Medicaid costs above what was required on December 31, 2009. It also clarifies that voluntary contributions by local governments are not to be considered to be required contribution, and applies this provision to the similar requirement under ARRA, which prohibited states from increasing the local share of Medicaid costs as a condition for receipt of the temporary FMAP increase. The County pursued the voluntary contribution clarification because the Centers for Medicare and Medicaid Services (CMS) had interpreted intergovernmental transfers and certified public expenditures to be required local government contributions.

Medicaid Enrollment: Each state is required to establish a system with websites which enable individuals to apply for and enroll in Medicaid, CHIP, or private coverage through newly created health exchanges. The Secretary of Health and Human Services (HHS) also is directed to create a single form to apply for Medicaid, CHIP, or Federal tax credits for health coverage through the exchange, and to ensure that a system is in place in each state to ensure that any individual applying for coverage under the exchange who is found to be eligible for Medicaid or CHIP is enrolled under such program. Any CHIP-eligible child who cannot enroll into CHIP (Healthy Families in California) would be eligible for tax credits for health coverage through the exchange. A state's exchange may enter into a contract with the State Medicaid agency to determine eligibility for tax credits. The new enrollment procedures and website are to be in place by 2013.

Hospitals also would have the option to make presumptive Medicaid eligibility determinations, based on preliminary information, for any individual who may be eligible for Medicaid, effective in 2014.

Medicaid Eligibility Maintenance-of-Effort (MOE) Requirement: States are required to maintain current Medicaid eligibility levels, procedures, and methodologies through December 31, 2013 for adults and September 30, 2019 for children (including under CHIP). In effect, the new law extends the Medicaid eligibility MOE requirement for receipt of the temporary Medicaid FMAP increase under ARRA, which prevents the State of California from reducing Medicaid eligibility. However, after this MOE requirement sunsets, the pre-existing authority of states to reduce Medicaid eligibility is restored.

Medicaid Disproportionate Share Hospital (DSH) Reductions: Medicaid DSH allotments to states would be reduced by $18.1 billion in Federal Fiscal Years (FFY) 2014 through 2020, increasing from $500 million in 2014 to $600 million in 2015 and 2016, $1.8 billion in 2017, $5 billion in 2018; $5.6 billion in 2019; and $4 billion in 2020. To put these DSH reductions in perspective, this $18.1 billion reduction is small compared to the $40.4 billion in estimated DSH reductions under the Balanced Budget Act of 1997 when DSH was cut to help finance increases in mandatory spending, such as the newly creating State Children's Health Insurance Program, which expanded health coverage to children with incomes too high to qualify for Medicaid.

The Secretary of Health and Human Services (HHS) is directed to reduce state DSH allotments using a methodology which imposes the largest percentage cuts on states that have the lowest percentage of uninsured persons or do not target their DSH payments on hospitals with high volumes of Medicaid inpatients and have high levels of uncompensated care (excluding bad debt). Just as under current law, each state will determine DSH payments to individual hospitals. Therefore, the impact on individual hospitals, including the County's, cannot be estimated with any certainty.

Medicaid Primary Care Payment Rates: Medicaid payment rates to primary care physicians for furnishing primary care services are required to be no less than 100% of Medicare payment rates during FFYs 2013 and 2014 with 100% Federal reimbursement of the increased cost of meeting this requirement.

Medicaid Community First Choice Option: States are provided a new "Community First Choice Option" to provide home and community-based attendant services and supports to individuals with disabilities who are Medicaid eligible and who require an institutional level of care, effective on October 1, 2011. States exercising this option will receive a six percentage point increase in its FMAP for the cost of such services.

Removal of Barriers to Providing Home and Community-Based Services: The bill includes provisions aimed at removing barriers to providing home and community-based services as an alternative to more costly institutionalized long-term care, including

through newly promulgated regulations to ensure that all states develop service systems promoting home and community-based services (HCBS). It also provides other new state options for offering HCBS and other non-institutionally based long-term care services, including personal care services, through waivers or a state plan amendment (SPA). States, which divert persons from more costly nursing home care through HCBS using a SPA, may provide HCBS to individuals with incomes up to 150% FPL, not to exceed 300% of the SSI benefit rate. Incentive payments in the form of a two or five percentage point increase in the FMAP for non-institutionally based long-term care services, including HCBS, will be available to participating states from October 1, 2011 through September 30, 2016, subject to a national cap of $3 billion in Federal matching funds.

New State Medicaid Option to Provide Health Homes for Enrollees with Chronic Conditions: States are provided a new option under which Medicaid recipients with at least two chronic conditions (or at-risk of developing a second chronic condition) can designate a provider as their medical care through which they would receive comprehensive, coordinated, and timely high-quality services. Chronic conditions are defined to include asthma, diabetes, heart disease, a mental health condition, substance abuse disorder, and being overweight. States which exercise this option would receive a higher 90% FMAP for such services for the first eight quarters in which the state plan amendment is in effect. This option becomes available in 2011.

Incentives for Prevention of Chronic Disease in Medicaid: A new program is established to provide grants to states to provide incentives for Medicaid beneficiaries to participate in programs which promote healthy lifestyles and prevent chronic diseases. The bill appropriates $100 million for a 5-year period beginning on January 1, 2011 to fund grants covering a time period of at least three years.

New Section 1115 Demonstration Project Requirements: The HHS Secretary is required to issue regulations governing applications or renewals for any Section 1115 demonstration project that would affect eligibility, enrollment, benefits, cost-sharing, or financing under Medicaid or CHIP within 180 days of the bill's enactment. The regulations shall provide for: public notice and comment process, including after a state's application is received by the Secretary; requirements relating to project goals, Federal and state cost and coverage projections, and specific State plans to ensure compliance with Medicaid and CHIP laws; state reporting procedures; and periodic evaluation by HHS. California's Hospital Financing Waiver is a Section 1115 Demonstration Project. Therefore, if the new regulations, in fact, are issued before the State's waiver renewal is submitted and/or approved, the regulations could apply to the State's waiver renewal unless pending waiver applications are exempt from any new requirements.

Center for Medicare and Medicaid Innovation: A new Center for Medicare and Medicaid Innovation (CMI) is to be created within the Centers for Medicare and Medicaid Services (CMS) to test innovative payment and service delivery models for providing health care to Medicare or Medicaid recipients by January 1, 2011.

Medicaid Global Payment Demonstration Project: The HHS Secretary in coordination with the CMI is required to establish a demonstration project in up to five states under which a participating state shall adjust their current payment structure for safety net hospitals from a fee-for-service structure to a global capitated payment model. The demonstration project shall be conducted during FFYs 2010 through 2012. The bill provides that budget neutrality requirements for Section 1115 demonstration projects will not apply.

Demonstration Project to Evaluate Integrated Care Around a Hospitalization: The HHS Secretary is required to establish a Medicaid demonstration project to evaluate the use of bundled payments for the provision of integrated care to Medicaid beneficiaries for episodes of care that includes a hospitalization and for physician services provided during a hospitalization. This demonstration project, which shall be conducted in up to eight states, as determined by the Secretary, will begin in 2012.

Medicaid Emergency Psychiatric Demonstration Project: The HHS Secretary is required to establish a three-year Medicaid emergency psychiatric demonstration project under which participating states would be required to reimburse certain institutions for mental disease (IMDs) for care provided to Medicaid beneficiaries between age 21 and 65 who are in need of medical assistance to stabilize an emergency medical condition. The Secretary shall select the participating states on a competitive basis. The bill appropriates $75 million in FFY 2011, which would be available for obligation through December 31, 2015 for this project.

Medicaid Prescription Drug Rebates: The bill increases the size of the minimum manufacturer rebates received by state Medicaid agencies for prescription drugs, including from 15.1% to 23.1% of the average manufacturer price (AMP) for single source brand-name drugs and from 11% to 13% of AMP for generic drugs. It also extends the rebates to prescription drugs purchased and dispensed by Medicaid managed care organizations.

Medicaid-Funded Public Health Services: The current Medicaid state option to provide diagnostic, screening, preventive, and rehabilitation services is expanded to include evidence-based clinical preventive services recommended by the U.S. Preventive Services Task Force and immunizations for adults recommended by

the Advisory Committee on Immunization Practices without cost-sharing. States would receive a one percentage point higher FMAP for these services, effective in 2013.

Effective immediately, states are provided a new option of providing family planning services to non-pregnant individuals with incomes up to the highest level applicable to pregnant women under a state Medicaid or CHIP plan and to individuals eligible under existing Section 1115 waivers which provide family planning services, such as in California. Under this new option, states are allowed to make a presumptive eligibility determination for these services before Medicaid applications are processed. Effective in FFY 2011, states are required to provide tobacco cessation services to pregnant women under Medicaid without cost-sharing.

OTHER PUBLIC HEALTH AND PREVENTION PROVISIONS

The bill establishes a new Prevention and Public Health Fund ("Fund"), and appropriates the following amounts for the Fund: $500 million in FFY 2010; $750 million in 2011; $1 billion for 2012; $1.25 billion in 2013; $1.5 billion in 2014; and $2 billion in 2015 and each subsequent fiscal year. The Fund may be used by the HHS Secretary to increase funding over the FFY 2008 level for programs authorized by the Public Health Service Act for prevention, public health, and wellness activities, including new programs authorized under the bill, which include:

- Community Transformation Grants, which would be awarded through competitive grants to state and local governments, Indian tribes, and non-profit organizations for community preventive health activities. Such sums as may be authorized for such grants in FFYs 2010 through 2014;

- Education and Outreach Campaign Regarding Preventive Benefits, which is a national public-private partnership for a prevention and health promotion outreach and education campaign. Funding for the campaign shall not exceed $500 million and shall take priority over Centers for Disease Control and Prevention (CDC) grants to states and other entities for similar purposes and goals;

- Epidemiology-Laboratory Capacity Grants, which would be awarded to state and local public health departments and Indian tribes that meet criteria established by CDC, for use in improving "surveillance for, and response to, infectious diseases and other conditions of public health importance." The bill authorizes $190 million a year in FFYs 2010 through 2013; and

- Healthy Aging, Living Well Grants, which would be awarded through competitive grants to state and local public health departments and Indian tribes for five-year

pilot programs to provide public health community interventions, screenings, and clinical referrals for individuals who are between 55 and 64 years of age. Such sums as may be authorized for such grants in FFYs 2010 through 2014.

The bill also includes a new Federal nutrition labeling requirement that chain restaurants with more than 20 stores must post calorie counts for standard menu items on their menu boards as well as listing nutritional content for standard menu items on menus or other readily available written format. Unlike a similar State law requirement, caloric content also must be printed on drive-through menu boards and be listed adjacent to food items offered in a salad bar, buffet or cafeteria line, and in vending machines. These new nutrition labeling provisions do not preempt existing state or local laws. The HHS Secretary is required to issue proposed regulations within one year of the date of enactment.

OTHER HEALTH PROVISIONS

Other health provisions in the bill of County interest include:

Graduate Medical Education Residency Slots: Language is included which protects graduate medical education residency slots for MLK-Harbor Hospital from redistribution to other hospitals under the bill's provisions which, otherwise, provide for the redistribution of unused residency slots. Language also is included which protects residency slots under the LAC-USC affiliation agreement regarding residency slots by allowing hospitals to retain up to 35% of unused slots.

Children's Health Insurance Program (CHIP): For FFYs 2016 through 2019, each state will receive an increase in its Federal CHIP match rate of 23 percentage points, subject to a match rate cap of 100%. This means that the Federal match rate for CHIP (Healthy Families) in California will increase from 65% to 88% during that time period. States are required to maintain current income eligibility levels for CHIP through September 30, 2019.

Early Childhood Home Visitation Program: A new early childhood home visitation grant program is established to promote improvements in maternal and prenatal health, infant health, child health and development, and school readiness. The bill appropriates $100 million for FFY 2010, $250 million for 2011, $350 million for 2012, $400 million for 2013, and $400 million for 2014 for the new program.

Elder Justice Act: Provisions of the Elder Justice Act, which are aimed at preventing and eliminating elder abuse, were incorporated into the bill. Most notably, it establishes a new adult protective services program under which formula grants would be provided

to states. The new law authorizes $100 million a year in FFYs 2011 through 2014. Funding later must be made available under annual appropriations bills.

Health Workforce Grants: The bill authorizes appropriations for various health workforce education and training grants, including grants to educate and train mid-career public health and allied health professionals; train direct care workers employed in long-term care settings; train dentists; retain nurses; train primary care physicians; and repay educational loans of public health professionals. Funding later must be made available under annual appropriations bills.

State Medical Tort Litigation Demonstration Programs: A new demonstration program is established under which the HHS Secretary may award grants to states for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. The bill authorizes $50 million a year in FFYs 2011 through 2015. Funding later must be made available under annual appropriations bills.

Medicare, Medicaid and CHIP Program Integrity: The bill requires the HHS Secretary to establish procedures for screening health providers and suppliers participating in Medicare, Medicaid, and CHIP within 180 days to reduce fraud, waste, and abuse. Based on the risk of fraud, waste, and abuse for each category of provider or supplier, the level of screening shall include, at minimum, licensure checks and also may include fingerprinting, criminal background checks, database checks, and unannounced site visits. States are required to comply with the new provider and supplier screening and oversight requirements under Medicaid and CHIP. Other Medicare, Medicaid, and CHIP program integrity provisions include:

- Requiring Medicaid and Medicare overpayments to be reported and returned within 60 days from the date the overpayment was identified or any corresponding cost report is due;
- Subjecting any individual or entity that makes false statements or misrepresents material facts in any application, agreement, or contract to participate or enroll as a provider or supplier under Medicare or Medicaid to exclusion from participating as a provider or supplier;
- Reducing the maximum period for the submission of Medicare claims from three years to one year after the date of service;
- Expanding the Recovery Audit Contractor (RAC) Program under which audit contractors seek to identify underpayments/overpayments and recoup overpayments to Medicaid by no later than December 31, 2010. The program currently is used only under Medicare;

- Requiring states to terminate individuals or entities from their Medicaid programs if they were terminated under Medicare or another state's Medicaid program;
- Requiring states to exclude individuals or entities from participation in Medicaid if the individual or entity owns, controls, or manages an entity that has delinquent unpaid overpayments and that has been suspended, excluded, or terminated (or is affiliated with an individual or entity that has been suspended, excluded, or terminated) from participation under Medicaid.

Background Checks for Employees of Long-Term Care Facilities and Providers: The HHS Secretary is required to establish a nationwide program for national and state background checks (including fingerprint checks) for direct patient access employees of long-term care facilities and providers, including nursing homes, home health agencies, hospice care providers, personal care service providers, and adult day care providers who receive Medicare or Medicaid payments. Federal matching funds equal to three times the state's contribution will be provided, not to exceed a cap of $3 million for newly participating states and $1.5 million for previously participating states.

Standards for Accessible Medical Diagnostic Equipment: Within 24 months of the date of enactment, the Architectural and Transportation Barriers Compliance Board, in consultation with the Food and Drug Administration, is required to issue regulatory standards to ensure that medical diagnostic equipment, such as examination tables, weight scales, and radiological equipment, in hospitals, clinics, and other health facilities are "accessible to, and usable, by individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible."

Excise Tax on High-Cost Employer-Sponsored Health Plans: As amended by the budget reconciliation bill (H.R. 4872), a new 40% excise tax on annual health insurance premiums under employer-sponsored plans that exceed a threshold of $10,200 for individual and $27,500 for family coverage with a higher threshold of $11,850 for individual and $30,950 for family coverage for employees in high-risk occupations, such as law enforcement officers and firefighters, and for retired employees age 55 or older who are not Medicare eligible. It also provides that the thresholds would be increased for 2018 if health insurance premiums grow higher than expected between now and 2018. In addition, the tax thresholds also are adjusted higher for employees of an employer with a relatively high percentage of older or female employees. After 2018, the thresholds would be adjusted annually for the change in the Consumer Price Index (CPI). Under the previous Senate-passed version, the excise tax would have taken effect in 2013 with significantly lower tax thresholds.

Medicare Payroll Tax for High Wage Workers: The employee portion of the Medicare payroll tax rate is increased by 0.9% from 1.45% to 2.35% on earned income for individuals in excess of $200,000 per year or $250,000 for a married couple. The combined wages of spouses will be counted in determining whether the tax threshold is exceeded. In addition, the taxable wage base would be expanded to include net investment income for individuals and married couples who meet these income thresholds. The employer portion of the Medicare payroll tax rate is not subject to the higher rate.

Flexible Spending Account Limit: A maximum annual limit of $2,500 would be imposed on health flexible spending account contributions, beginning in 2013, and adjusted annually for the change in the CPI in subsequent years.

We will continue to keep you advised.

WTF:RA
MT:er

c: All Department Heads
Legislative Strategist