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THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

Summary of Health Care Provisions

The American Recovery and Reinvestment Act of 2009 (the "Act") was enacted by Congress on February 13, 2009, and signed into law by the President on February 17, 2009.

The following is a brief overview of the significant health care related expenditures and policy provisions included in the Act:

Medicaid – The Act provides assistance for state Medicaid programs in the form of approximately $87 billion in additional federal medical assistance percentage ("FMAP") match rate payments to states, a temporary increase in disproportionate share hospital ("DSH") payments and moratoria on certain Medicaid regulations.

- **FMAP**: The Act provides for a general increase in the FMAP and additional upward adjustments for states with certain levels of unemployment, for the period beginning October 1, 2008 and ending December 31, 2010. The across-the-board increase for all states is 6.2% with bonus increases of 5.5%, 8.5% and 11.5% for states with certain increases in unemployment levels since January 1, 2006. To maximize the FMAP increase it receives, a state must maintain eligibility standards in place on July 1, 2008.

- **DSH Allotments**: The Act includes a provision that increases the DSH payments to states for FY 2009 by 2.5% and for FY 2010 by 2.5% over the FY 2009 amount, with subsequent years returning to 100% of allotments as determined under current law. New Hampshire's DSH program is currently under investigation; however, there is no indication that New Hampshire will not receive its increase.

- **Moratoria**: The Act extends moratoria on regulations for targeted case management, provider taxes and school-based administration and transportation services through June 30, 2009, and adds a moratorium on the implementation of "the final regulations relating to clarification of the definition of outpatient hospital facility services under the Medicaid program published on November 7, 2008" through June 30, 2009. It also includes a (non-binding) Sense of Congress that DHHS should not promulgate regulations concerning payments to public providers, graduate medical education and rehabilitative services.

Medicare – The Act provides for moratoria on certain Medicare regulations, such as the payment reduction to teaching hospitals related to capital payments for indirect medical education, and includes a technical correction regarding payments for long-term care hospitals.

Health IT – The Act allocates approximately $19 billion over the next ten years to encourage the development of health information exchanges ("HIE") and the adoption of electronic health records ("EHR").

- **Grants and Loans**: Approximately $2 billion of the total amount is in appropriated funds for discretionary grants, loans and technical assistance programs designed to aid providers with the adoption of EHR and the development of HIE. These funds will be disbursed by various agencies within DHHS, either directly to providers – including private physician offices – or to other entities like states or non-profit organizations.

- **Medicare/Medicaid Payment Incentives**: The remaining allocated amounts will take the form of Medicare and Medicaid payment incentives. The Act identifies 4 priority areas for spending: (1) establishing HIE; (2) EHR adoption; (3) workforce training; and (4) new technology research and development. In order to qualify for EHR funding, providers are required to connect to an HIE, which means funding is dependent on state action to establish HIEs. The payment incentives do not become available until 2011. The Act includes payment incentives for critical access hospitals that are meaningful users of EHR.

Privacy Provisions – The Act requires that DHHS appoint a new "Chief Privacy Offer" and makes several changes to HIPAA regarding uses and disclosures of protected health information ("PHI").

HIPAA Changes:

- **Application of Provisions Directly to Business Associates**: The Act applies the security and privacy provisions of 45 CFR 164, and penalties for violation of those security and privacy provisions, directly to *business associates* to the same extent as a covered entity.

- **Disclosure of Security Breaches and Additional Business Associate Agreements**: The Act requires that, in the event a covered entity discovers a security breach, the covered entity must notify each individual whose "unsecured" PHI has been, or is reasonably believed by the covered entity to have been, accessed, acquired or disclosed. The Act requires breach notifications by vendors of personal health records and certain other non-HIPAA covered entities, and requires entities engaging in data transmission of PHI or certain EHR services to enter into a business associate agreement with the covered entity on whose behalf it is performing the service.

- **Individual Requests for Restrictions on Disclosure**: The Act requires covered entities to restrict the disclosure of PHI at an individual's request if: (i) the disclosure is to a health plan for purposes of carrying out payment or health care operations; and (ii) the PHI pertains solely to an item or service for which the provider has been paid out-of-pocket in full.

- **Enforcement**: The Act strengthens HIPAA's civil penalties and enforcement provisions.

COBRA Provisions – COBRA entitles eligible individuals to continue under a group plan for up to 18 months, but the individuals must pay 100% of the premiums. The Act provides a subsidy for individuals with COBRA coverage in the form of premium reductions.

- **Amount**: The Act provides a 65% subsidy to individuals, and their spouses and dependents, for COBRA premiums (or premiums for state law-mandated continuation coverage for small employers). The subsidy directly reduces the costs of premiums (i.e., the individual pays only 35% of the premium cost).

- **Qualifications**: To qualify, the individual must have been, or be, involuntarily terminated between September 1, 2008 and December 31, 2009, and have income of less than $125,000 (for an individual) or $250,000 (for a family). If the individual otherwise qualifies but failed to initially elect COBRA coverage between September 1, 2008 and enactment of the Act, the individual will be given an additional 60 days to elect.

- **Duration**: The subsidy terminates upon the earlier of (i) the date the coverage would otherwise terminate; (ii) 9 months; (iii) the individual becoming eligible for new coverage; or (iv) the individual becoming eligible for Medicare.

- **Reimbursement**: The employer must initially bear the cost of the 65% subsidy, and is reimbursed through an offset of payroll taxes or, to the extent the premiums exceed such taxes, through a direct payment from the Secretary of Labor; provided that the 35% of premium due from the individual must be paid as a condition for reimbursement. Employees who have already paid 100% of the premiums for subsidy eligible coverage must be given the benefit of the subsidy through either reimbursement from the employer or future premium offsets (or both).

- **Employer Notices:** By April 18, 2009, employers must provide updated notices to eligible employees currently covered by COBRA and eligible employees who did not previously elect COBRA coverage of their eligibility for the subsidy. In addition, notices sent to newly eligible employees must include information regarding the subsidy.

- **Change in Coverage**: The Act also allows for individuals to elect different coverage offered by the employer as COBRA coverage, subject to certain requirements (including agreement by the employer to participate in the coverage change option).

Community Health Centers/FQHCs – The Act provides $500 million for services provided at community health centers and $1.5 billion in grants, and for renovations, repairs and acquisitions of EHR for Federally Qualified Health Centers operating under Section 330 of the Public Health Act.

For further questions, please contact Adam C. Varley at acv@rathlaw.com or Lucy C. Hodder, Chair of the Healthcare Practice Group at lch@rathlaw.com.

This information should not be construed as legal advice or relied upon to resolve legal problems.