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# An Overview of Major Health Provisions Contained in the American Recovery and Reinvestment Act of 2009

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## Issue Brief

### **An Overview of Major Health Provisions Contained in the American Recovery and Reinvestment Act of 2009**

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## *Introduction*

On February 17, 2009, President Barack Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) into law. One of the most sweeping pieces of economic legislation ever enacted, ARRA not only provides hundreds of billions of dollars in new health and health care spending but also makes comprehensive reforms in health law and policy, particularly in the area of health information law, including health information technology (HIT) adoption and health information privacy. In some cases, the legislation creates new law, while in others it significantly amends existing laws, in particular Medicare and Medicaid.

This comparative analysis presents a detailed overview of key elements of the House and Senate legislation, as well as the final conference agreement enacted into law. The analysis covers the following topics:

- HIT adoption (establishment of program, privacy improvements, Medicare and Medicaid payment incentives for adoption)
- Medicaid economic stimulus reforms
- Comparative effectiveness
- Extending health insurance to the unemployed (COBRA)
- Modification of health care tax credit under Trade Act
- Health centers investments
- Primary health care workforce
- Public health investments

## *Health Information Technology Adoption*

The ARRA establishes the Health Information Technology for Economic and Clinical Health (HITECH) Act, a federal program that supports (both structurally and economically), the development of HIT. The program codifies and directly funds the Office of the National Coordinator for Health Information Technology and authorizes the National Coordinator to direct new federal investments in HIT capability in accordance with the development of comprehensive federal standards. An HIT Policy Committee, comprised of government-appointed stakeholders and experts, will assist HHS policymaking in areas such as the formation of a nationwide technology infrastructure that allows for electronic use and accurate exchange of health information, data collection, and adoption of technologies that facilitate the encryption of data and accounting of disclosures of health information. The policy committee is specifically directed to make recommendations regarding, among other things, the development of electronic data collection methods that provide for the collection of race, ethnicity, primary language, and gender data. A separate HIT Standards Committee will make recommendations regarding the development of HIT standards, implementation specification, and certification criteria.

The HIT provisions also amend Medicare and Medicaid to provide monetary incentives to spur electronic health records (EHR) adoption. In the case of Medicare, incentives are targeted at physicians (practicing in both fee-for-service settings and, in certain cases, Medicare Advantage Organizations) and hospitals. Eligibility for incentive payments is conditioned on the ability of adopters to demonstrate “meaningful use” of EHRs, including use in practice, the use of interoperable technology, and the ability to report data. Incentive payments are phased out over a 6-year time period followed by penalties imposed on non-adopters. The Medicaid HIT incentives provide 100% federal funding to enable EHR adoption and use by several classes of Medicaid providers (physicians, nurse midwives nurse practitioners, dentists, certain physician assistants, children’s hospitals, and general acute care hospitals) that serve a high volume of Medicaid (and in the case of federally qualified health centers and rural health clinics, “needy”) patients. As with the Medicare incentives, the Medicaid incentives are provided on a phased-down basis.

The ARRA revises existing health information privacy protections to strengthen privacy and security standards generally, provides for the notification of unauthorized breaches and an accounting of authorized disclosures of health information, guards against the commercial use of personal health information, and clarifies that marketing based on personal health information cannot be considered a health care operation.

#### *Medicaid Stimulus Funding*

The ARRA provides for a temporary increase in federal Medicaid contributions, with a base contribution to all states, enhanced payments (in the form of a reduced state contribution) in high unemployment states, and additional disproportionate share hospital allocations. In addition, the legislation extends a previously-enacted moratorium on certain Medicaid regulations promulgated by the Bush Administration. The final legislation does not include a key provision in the House bill, which would have extended coverage to unemployed but otherwise ineligible low-income families. The final legislation does extend transitional Medicaid assistance to persons moving from welfare to work and contains important new protections for American Indians and Native Alaskans.

#### *Comparative Effectiveness*

The ARRA establishes a Federal Coordinating Council for Comparative Effectiveness Research that will assist the Department of Health and Human Services (HHS), the Veterans Administration (VA), the Department of Defense (DOD) and other federal agencies to coordinate and conduct comparative effectiveness and related health services research. The law provides \$1.1 billion to be used to conduct research on clinical outcomes, effectiveness, risk, and benefits of medical treatments and services and encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.

### *COBRA Extended Health Insurance Coverage*

The Act creates an immediate short term subsidy (“premium assistance”) for COBRA coverage for individuals who were involuntarily terminated from employment between September 1, 2008, and December 31, 2009. However, premium assistance is only available to individuals with annual incomes below \$125,000 (single) or \$250,000 (couples). The subsidy is equal to 65% of the required premium and lasts a maximum of nine months. A special election period is created to allow individuals who are eligible for the subsidy to elect COBRA coverage even if they have previously not done so. The subsidy is also available for health care continuation coverage if required by the states for employees not otherwise covered by COBRA (*e.g.*, employees of small employers). Two provisions that appeared in the House bill have been dropped from the final version of the Act: (1) authorization for states to extend Medicaid coverage to certain unemployed individuals; and (2) the extension of unsubsidized COBRA coverage to older and long-service workers until they reach Medicare eligibility or are covered under another group health plan.

### *Health Care Tax Credit under Trade Assistance Act*

Under the Trade Act of 2002, “eligible individuals” and their qualifying family members are eligible for a refundable tax credit for a portion of the health care premium they pay for “qualifying health insurance” during each month they are eligible. The Act increases on a temporary basis (until 2010) the amount of the tax credit to 80% of the premium (including premiums for COBRA coverage). This credit is available on an advance basis. “Eligible individuals” include Trade Adjustment Assistance Act (TAA) recipients and individuals over 55 receiving pensions from the Pension Benefit Guaranty Corporation (PBGC) as long as the individuals do not have other specified health coverage (such as Medicare, Medicaid or SCHIP, or coverage as an employee under an employer-sponsored health plan where the employer provides at least a 50% subsidy). The Act also includes a number of coordinating amendments to COBRA to align those rules with the TAA provisions.

### *Community Health Centers and Primary Health Care Workforce*

The ARRA contains investments in health centers and the primary health care workforce. Health center investments include \$1.5 billion for health center construction, renovation, equipment, and acquisition of HIT, \$500 million in additional operating funds, and the Medicaid HIT adoption incentives described above.

In addition, the ARRA makes a \$500 million investment in the primary health care workforce, with \$300 million targeted to the National Health Service Corps and \$200 million to primary care training programs authorized under Titles VII and VIII of the Public Health Service Act.

*Public Health Emergency and Wellness and Prevention Funds*

The ARRA creates two separate funds for public health support. The Public Health and Social Services Emergency Fund consists of \$50 million for improvements to HHS information technology security. The Prevention and Wellness Fund consists of \$1 billion for three specific tasks: (1) \$650 million for evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes that address chronic disease rates; (2) \$300 million for CDC immunization program; and (3) \$50 million to States to implement healthcare-associated infections reduction strategies.