March 25, 2010

CCH BRIEFING *Special Report*

Congress Passes Reconciliation Bill Amending Reform Law

Highlights

- ✔ Closing the Medicare Part D "donut" hole
- ✔ Revising Medicare Part C payments
- ✔ Changes in disproportionate share payments to hospitals
- ✔ Physician self-referral changes
- ✔ Medicaid payments to physicians
- ✔ Increased funding for federal anti-fraud programs
- ✔ Flexible spending arrangements
- ✔ Reduction in individual penalty regarding health insurance
- ✔ Tax on high-cost insurance

Inside

Congress on March 25, 2010, approved the Health Care and Education Reconciliation Act of 2010 (H.R. 4872), which makes changes to the Patient Protection and Affordable Care Act (P.L. 111-148). The House of Representative originally approved the Reconciliation Act on March 21; the Senate approved the legislation on March 25, without two education provisions. The House then approved the Senate-passed version of H.R. 4872 later the same day.

There are two titles to the Reconciliation Act: Title I focuses on insurance coverage, Medicare, Medicaid, fraud and abuse in federal health programs, and revenue provisions; Title II focuses on education and health.

Medicare

Closing the "donut" hole. The Reconciliation Act provides a $250 rebate for all Medicare Part D enrollees who enter the "donut" hole—where the beneficiary must pay for all prescription drug spending out of pocket—in 2010, and will receive their payment no later than the 15th day of the third month following the end of the quarter. Each enrollee is limited to one payment.

The House reconciliation package also builds on pharmaceutical manufacturers' 50 percent discount on brand-name drugs beginning in 2011 to completely close the donut hole with 75 percent discounts on brand-name and generic drugs by 2020. The coverage for a beneficiary who has coinsurance for covered Part D drugs that are not applicable drugs are equal to the generic-gap coinsurance percentage or actuarially equivalent to an average expected payment of such percentage of costs for covered part D drugs that are applicable drugs.

Medicare Advantage payments. The Reconciliation Act requires that beginning in 2014, Medicare Advantage (MA) plans spend at least 85 percent of their revenue on medical costs or activities that improve the quality of care, rather than profit or overhead. An MA plan that fails to satisfy the spending requirement would be subject to monetary penalties, membership enrollment postponement, or termination from the program.

The Reconciliation Act repeals two sections of the Affordable Care Act related to payments to MA plans and the application of a coding intensity adjustment to MA plans. The Act freezes MA payments in 2011. Beginning in 2012, MA benchmarks would be reduced relative to current levels. Benchmarks would vary from 95 percent of Medicare spending in high-cost areas to 115 percent of Medicare spending in low-cost areas. The MA applicable beneficiary rebate percentage would be revised to 75 percent or the applicable percentage for plans beginning after January 1, 2010. The Act

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includes an incentive system to increase payments to high-quality plans by up to 5 percent by 2014.

CMS would have the authority to adjust MA risk scores for observed differences in coding patterns relative to Part A and B payments beyond 2010. The adjustment factor will be applied to risk scores until the Secretary implements risk adjustment using Medicare Advantage diagnostic, cost, and use data.

The Reconciliation Act repeals the Comparative Cost Adjustment Demonstration Project.

Comment: *The comparative cost adjustment demonstration project required traditional fee-for-service Medicare to compete with private Medicare Advantage plans in selected regions beginning in 2010 to test whether the competition would improve health care delivery for all beneficiaries, as well as provide for beneficiary savings and reduce governmental costs. The demonstration program was set to begin January 1, 2010, and be phased-in over a four year period.*

Part D payments. The low-income Medicare Part D Benchmark premium will be determined before the application of the monthly rebate for that plan and year involved, and in the case of a qualifying plan, before the application of the increase for the plan and year involved.

Disproportionate share payments. The Reconciliation Act advances Medicare disproportionate share hospital cuts to begin in fiscal year 2014, instead of 2015. Instead of the amount of disproportionate share hospital payment expected to be received, the Secretary would pay the hospital 25 percent of such amount, plus an additional amount based upon a factor equal derived from: (1) the number of uninsured individuals under age 65 for 2014 through 2017, and (2) the number of uninsured individuals for 2018 and 2019.

Market basket updates. The Act revises the market basket update for inpatient psychiatric facilities, inpatient and outpatient hospitals, long-term care hospitals, and inpatient rehabilitation facilities.

Physician ownership. The Act changes the date from August 1, 2010, to December 31, 2010, after which physician ownership of hospitals to which they self-refer is prohibited. There is a limited exception for grandfathered physician-owned hospitals that are not the sole hospital in a county and treat the highest percentage of Medicaid patients in their county.

Diagnostic imaging. The Act sets the assumed utilization rate at 75 percent for the practice expense portion for expensive diagnostic imaging services with respect to fee schedules established for 2011 and subsequent years.

Physician fee schedule. For services furnished during 2010 under the Medicare Physician Fee Schedule, the Act requires the employee wage and rent portions of the practice expense geographic index to reflect one-half, instead of three-quarters, of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

Qualifying hospitals. Congress will make available $400 million from the Federal Hospital Insurance Trust Fund for payments to qualifying hospitals for FYs 2011 and 2012.

Comment: *A qualifying hospital is a "subsection D" hospitals that is located in a county that ranks—in age, sex, and race adjusted for benefits under Parts A and B per enrollee—within the lowest quartile of such counties in the country.*

Medicaid

Special payments. The Reconciliation Act eliminates the provision for a permanent 100 percent federal matching rate for Nebraska for the Medicaid costs of newly eligible individuals. Federal Medicaid matching payments for the costs of services to newly eligible individuals at the following rates in all states except expansion states would be as follows:

- 100 percent in 2014, 2015, and 2016;
- 95 percent in 2017;
- 94 percent in 2018;
- 93 percent in 2019; and
- 90 percent thereafter.

For expansion states, the state share of the costs of covering nonpregnant childless adults would be reduced by:

- 50 percent in 2014;
- 60 percent in 2015;
- 70 percent in 2016;
- 80 percent in 2017; and
- 90 percent in 2018.

Medicaid physician payments. Medicaid payment rates to primary care physicians for furnishing primary care services can be no less than 100 percent of the Medicare payment rates in 2013 and 2014. States would receive 100 percent federal funding for the incremental costs of meeting this requirement.

Medicaid DSH. The Reconciliation Act will lower the reduction in federal Medicaid DSH payments from $18.1 billion to $14.1 billion and advance the reductions to begin in FY 2014. The Secretary of HHS must develop a methodology for reducing federal DSH allotments to all states in order to achieve the mandated reductions. The federal DSH allotment for a state that has a $0 allotment after FY 2011 would be extended through FY 2013.

Funding for territories. The Act raises the caps on federal Medicaid funding for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the period beginning July 1, 2011, and ending on September 30, 2019, by such amounts that the total additional Medicaid payments would equal $6,300,000,000. The Act eliminates the provision of the Affordable Care Act that provided that beginning in fiscal year 2014, payments made to each of the territories would not account against the spending caps expended for medical assistance for newly eligible, nonpregnant, childless adults.

Territories will have the option to establish a Health Benefit Exchange and will be treated as a state for payment purposes. If the territory does not elect to establish an Exchange, it will instead be provided an increase in the dollar limitation applicable under Sections 1108(f) and (g) of the Social Security Act, with the increase not taken into account in other calculations.

Community First Choice delay. The Reconciliation Act delays the date on which states may begin to provide the Community First Choice option to eligible individuals from October 1, 2010, until October 1, 2011. This program is a way for states to offer medical assistance for home- and community-based attendant services and supports for individuals who are eligible for medical assistance under a state Medicaid plan.

Drug rebates. The Act clarifies, regarding the rebate obligation for new formulations of existing drugs, that the term "line extension" is defined as a new formulation of a drug, such as an extended release formulation.

Fraud and abuse

Community mental health centers. The Reconciliation act further defines a "community mental health center" as a facility that provides more than 40 percent of its services to individuals who are not eligible for Medicare benefits, and provides them in a setting other than in an individual's home or inpatient residential setting.

Medicare prepayment medical review limitations. The Act repeals Sec. 1874A(h) of the Social Security Act to streamline Medicare prepayment medical review limitations. It also permits the Secretary to deny applications of Medicare enrollment submitted by providers or suppliers owing tax debt.

Fraud funding. The Act provides additional funding starting in 2011 for both the Health Care Fraud and Abuse Fund under Medicare and the Medicaid Integrity Program fraud.

DME fraud. If the Secretary determines that there is a significant risk of fraudulent activity among suppliers of durable medical equipment, the Secretary may withhold payment during the 90-day period beginning on the date of the first submission of a claim.

Employers

The Affordable Care Act, as amended by the Reconciliation Act, does not require employers to provide health insurance coverage. However, "large" employers that do not provide minimum essential coverage will be liable for an additional tax.

"Large" employers (essentially businesses with at least 50 employees) that fail to offer minimum essential coverage during any month for which a full-time employee has enrolled in a subsidized plan using the premium assistance tax credit of cost-sharing reductions would be liable for an additional tax. That penalty would equal the product of the applicable payment amount (with respect to any month, 1/12 of $2000) and the number of full-time employees employed by the employer during such month.

Comment: *As amended by the Reconciliation Act, the penalty would apply to employers with at least 50 employees but would subtract the first 30 workers from the payment calculations (e.g. a firm with 51 workers that does not offer coverage will pay an amount equal to 51 minus 30, or 21 times the applicable per employee payment amount.)*

Comment. *Generally, employees could be eligible for premium tax credits when employer-provided insurance costs 9.5 percent or more of the employee's household income or the employer plan's share of benefits is less than 60 percent. This type of coverage will not qualify as minimum essential coverage.*

Flexible spending arrangements. Flexible spending arrangement (FSA) contributions are capped at $2,500 (indexed for inflation). Under the Reconciliation Act, these changes apply for taxable years beginning after December 31, 2012.

Individuals

Individual responsibility. The Affordable Care Act, as amended by the Reconciliation Act, requires individuals to maintain minimum essential coverage beginning after 2013. Individuals who fail to maintain minimum essential coverage would be liable for a penalty.

The Affordable Care Act, as amended by the Reconciliation Act, imposes a nondeductible penalty of $95 per person without minimum essential coverage in 2014. The nondeductible penalty rises to $325 per person without minimum essential coverage in 2015 and to $695 per person without minimum essential coverage in 2016 and indexed for inflation thereafter.

Comment: *Prior to amendment by the Reconciliation Act, the Affordable Care Act set the penalties at $95 for 2014, $495 for 2015, and $750 for 2016.*

Additionally, amendments made by the Reconciliation Act raise the percent of income that is an alternative payment amount to the annual penalty from 0.5 percent to 1.0 percent in 2014, 1.0 to 2.0 percent in 2015, and 2.0 to 2.5 percent for 2016 and subsequent years.

Individual Responsibility

Year	Penalty	Percent of Income*
2014	$95	1%
2015	$325	2%
2016	$625**	2.5%

*In lieu of the flat penalty if greater
**Indexed for inflation thereafter

Coverage subsidies. The Affordable Care Act, as amended by the Reconciliation Act, also provides premium assistance tax credits and reduced cost sharing to qualified individuals. The credit is designed to guarantee that qualified individuals would not spend more than a specific percentage of their income on medical insurance premiums. Generally, these are individuals who cannot afford minimum essential coverage based on the relationship of their income to the federal poverty level. The health care package allows for the advanced payment of premium assistance credits.

The federal poverty level is determined based on family size. For example, a family of four with household income between $29,327 (approximately 133 percent of the current FPL) and $88,000 (approximately 400 percent of current FPL) would qualify for a premium subsidy. Likewise, individuals with household incomes between approximately $14,000 and $43,000 would qualify.

Comment: *The subsidy credit starts at 133 percent of the federal poverty level (FPL). At the same time, the health-care package expands Medicaid to cover those with income less than 133 percent of FPL.*

Comment: *The IRS will be responsible for determining eligibility for the premium assistance tax credit. Further, premium assistance tax credits would be disregarded for federal or federally-assisted programs.*

Funding Mechanisms

Tax on high-cost insurance. The Affordable Care Act, as amended by the Reconciliation Act, will impose a 40 percent nonrefundable excise tax on group insurers if annual premium payments exceed an inflation-adjusted $10,200 for individual coverage and $27,500 for family coverage beginning in 2018.

The Affordable Care Act, as amended, also provides higher premium levels for retirees and employees in certain high-risk professions: $11,850 for individual coverage and $30,950 for family coverage. Retired individuals age 55 and older would also be eligible for the higher thresholds.

Comment: *Employers will be required to disclose the value of employer-provided health insurance to employees annually on Form W-2.*

Comment. *Designed principally to limit so-called "Cadillac plans," the excise tax for these high-end policies would be imposed pro rata on issuers. For self-insured plans, the plan administrator (including employers that act as plan administrators) would pay the excise tax. The Affordable Care Act had originally applied application of the excise tax as of 2013. The Reconciliation Act delayed implementation until 2018 to give plans "time to implement and realize the cost savings of reform." Because of this delay, however, the Reconciliation Act eliminates the three-year transition relief that had been available in the Affordable Care Act for coverage in 17 high-cost states.*

Premium Tax Credits For Affordability

Household income*	Initial premium percentage	Final premium percentage
Up to 1 33%	2.0	2.0
133% up to 150%	3.0	4.0
150% up to 200%	4.0	6.3
200% up to 250%	6.3	8.05
250% up to 300%	8.05	9.5
300 % up to 400%	9.5	9.5 (and special indexing rules)

*Household income expressed as a percent of the federal poverty line**Indexed for inflation thereafter

Cost-of-living adjustments. While the Reconciliation Act raises the base dollar premium levels for classification as Cadillac plans (the original levels had been set at $8,500 for individuals and $23,000 for families), it takes away a more generous inflation-index in the original Affordable Care Act. The threshold amounts originally would have been indexed for inflation using CPI-U plus 1 percent. The Reconciliation Act keeps that inflation-adjusted calculation for 2018 and 2019 only. Thereafter, the amounts would be adjusted only using the base CPI-U. The dollar thresholds will be increased automatically in 2018 if the Congressional Budget Office is incorrect in its forecast of the premium inflation rate between 2010 and 2018. Estimates are that the new indexing will more than offset any benefits given under the higher base dollar premium levels.

The Reconciliation Act removes completely from the Affordable Care Act the value of dental and vision plan benefits from determining the excise tax thresholds. The Reconciliation Act also provides adjustments to the thresholds to account for plans that carry a higher premium cost because of the participants' age or gender.

Medicare payroll tax. The Affordable Care Act, as amended by the Reconciliation Act, broadens the Medicare tax base for higher-income taxpayers by imposing an additional 0.9 percent Medicare payroll tax on individual earned income over $200,000 ($250,000 for joint filers). The Reconciliation Act modifies the Medicare tax to include net investment income in the tax base. The tax on net investment income would not apply if modified adjusted gross income is less than $250,000 in the case of a joint return, or $200,000 in the case of a single return. Net investment income would consist of interest, dividends, royalties, rents, gross income from trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). Net investment income would be reduced by properly allocable deductions to such income.

Market sector fees. The Affordable Care Act, as amended by the Reconciliation Act, imposes annual nondeductible fees on various health-related industries, such as medical device manufacturers and importers, health insurance providers and others. The annual fees would be allocated across industry sectors according to market share. The Affordable Care Act, as amended by the Reconciliation Act, delays the effective dates of the taxes on sales of brand name pharmaceuticals by one year until 2011 and on health insurance providers for three years until 2014. The Affordable Care Act, as amended by the Reconciliation Act, also exempts qualified nonprofit insurance providers serving lower-income and other targeted groups and some voluntary employee benefit associations.

Comment. *The Affordable Care Act, as amended by the Reconciliation Act, removes an annual fee that would have been imposed on medical device manufacturers. However, as a trade-off, the Affordable Care Act, as amended by the Reconciliation Act, adds a 2.9 percent excise tax on medical device sales. However, certain medical devices routinely purchased by consumers, such as eyeglasses and hearing aids, would be exempt from the excise tax.*

Market Reforms

The Reconciliation Act also includes the following new requirements:

- Effective six months after enactment grandfathered plans must offer coverage to adult children to age 26 and eliminate waiting periods for coverage of greater than 90 days.
- Beginning in 2014, grandfathered plans must eliminate lifetime and annual limits on coverage (grandfathered plans in P.L. 111-148 are exempt from these provisions).
- Effective in 2013, eliminate the tax deduction for employers who receive Medicare Part D retiree drug subsidy payments (2011 in P.L. 111-148).
- Increase the annual fees imposed on health insurers, which are set to go to $14.3 billion in 2018 ($10 billion in P.L. 111-148). Provisions added to the reconciliation bill: only 50 percent of premiums are used to calculate the fee for non-profit insurers, and voluntary employee beneficiary associations (VEBAS) are exempt from the fee.