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Health care legislative and regulatory update

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Congress Passes Massive Health Care Reform Using Two Bills

Congress has passed the most sweeping health care reform measures since the enactment of Medicare in 1965 using two separate bills—the Senate's ***Patient Protection and Affordable Care Act*** (H.R. 3590*)* from December 2009*,* and the House's recent ***Health Care and Education Affordability Reconciliation Act of 2010*** (H.R. 4872) H.R. 4872 modifies a number of provisions in H.R.3590. The president signed H.R. 3590 into law on March 23. Together, the bills will extend health coverage to 32 million people. The Congressional Budget Office (CBO) estimates that the legislation will cost approximately $940 billion over 10 years, while reducing the federal deficit.

The legislation contains changes including increased tax credits to help people buy insurance by increasing the eligibility levels under Medicaid, in addition to more federal funding to states for Medicaid; closure of the Medicare prescription-drug doughnut-hole for seniors; and an expansion of the Medicare payroll tax for higher-paid Americans. A significant reduction to the Senate's 40-percent excise tax on high-cost premiums (because of a later effective date and increased thresholds) reduces the revenue it could have raised to a total of only $32 billion. Over the course of a decade that leaves a $116 billion hole. That hole however is filled by extending the Medicare payroll tax on unearned income for joint filers earning $250,000 or more and individuals making $200,000 and up.

According to CBO, the bills will, among other things, establish a mandate for most residents of the United States to obtain health insurance; set up insurance exchanges through which certain individuals and families could receive federal subsidies to substantially reduce the cost of purchasing that coverage; significantly expand eligibility for Medicaid; substantially reduce the growth of Medicare's payment rates for most services (relative to the growth rates projected under current law); impose an excise tax on insurance plans with relatively high premiums; and make various other changes to the federal tax code, Medicare, Medicaid and other programs.

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Changes impacting the largest budgetary items

The changes with the largest budgetary effects over the 2010-2019 period include:

- Increasing the subsidies for premiums and cost sharing that would be offered through the new insurance exchanges;
- Increasing the penalties for employers that do not offer health insurance and modifying the penalties for individuals who do not obtain insurance;
- Changing eligibility for Medicaid in a way that effectively increases the income threshold from 133 percent of the federal poverty level to 138 percent for certain individuals;
- Increasing the federal share of spending for certain Medicaid beneficiaries;
- Reducing overall payments to insurance plans under the Medicare Advantage program;
- Expanding Medicare's drug benefit by phasing out the "doughnut hole" in that benefit over 10 years;
- Modifying the design and delaying the implementation of the excise tax on insurance plans with relatively high premiums; and
- Increasing the rate and expanding the scope of a tax that would be charged to higher-income households.

Effects of the Legislation on Insurance Coverage

CBO estimates that by 2019, the combined effect of this legislation will be to reduce the number of nonelderly people who are uninsured by about 32 million, leaving about 23 million nonelderly residents uninsured. Under the legislation, the share of legal nonelderly residents with insurance coverage will rise from about 83 percent currently to about 94 percent.

Approximately 24 million people will purchase their own coverage through the new insurance exchanges, and there will be roughly 16 million more enrollees in Medicaid and the Children's Health Insurance Program (CHIP) than the number projected under current law. Relative to currently projected levels, the number of people purchasing individual coverage outside the exchanges will decline by about five million.

Under the legislation, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges. Approximately five million people will obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 29 million in that year.

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Costs

Below are a number of significant cost items as scored by CBO over the next 10 years:

Coverage Provisions

- Medicaid & CHIP Expansion Outlays (increased enrollment) $434 billion
- Exchange Subsidies and Related spending $464 billion
- Small Employer Tax Credits $40 billion
- Penalty Payments by Uninsured Individuals $-17 billion*
- Penalty Payments by Employers $-52 billion*
- Excise Tax on High-Premium Insurance Plans $-32 billion*
- Other Effects on Tax Revenues and Outlays $-48 billion*

* Negative amounts reduce cost to the government

Outlays

- Revision of certain market basket updates used to increase payments each year will be modified to incorporate a productivity improvement factor basket for providers that do not already incorporate such improvements $-156.6 billion
- Savings from the establishment of an Independent Payment Advisory Board $-15.5 billion
- Savings from changes to Medicare and Medicaid Disproportionate Share (DSH) payments $-36.1 billion
- Reductions in Medicare Advantage Plans $-135.6 billion
- Medicaid Prescription Drug Coverage $-38.1 billion
- Payment adjustments to Home Health $-39.7 billion
- Community Living Assistance Services and Supports $-70.2 billion

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Implementation Timeframes

The following timelines reflect the effective dates of various provisions. The list is not all inclusive, but identifies major issues. Some items are repeated in different years because portions of changes have different effective dates.

Medicare Providers

Hospital Inpatient and Outpatient Market Basket Rates of Increase –

FY 2010 - FY 2019 Medicare Adjustment Reduced between .10-.75

Inpatient Rehabilitation Facilities (IRFs) Market Basket Rates of Increase –

FY 2010 - FY 2019 Medicare Adjustment Reduced between .10-.75

Long-Term Care Hospitals (LTCHs) Market Basket Rates of Increase –

FY 2010 - FY 2019 Medicare Adjustment Reduced between .10-.75

MMSEA section 114(c) and (d) extended for one year.

Comment

Changes made to market basket updates as noted above are effective April 2010.

Home Health – Establishes a provider-specific cap of 10 percent of revenues that may be reimbursed from outlier payments, and provides for a 3.0 percent add-on payment for rural agencies, from April 1, 2010 to January 1, 2016.

Outpatient Therapy – Extends the outpatient therapy caps exceptions process through December 31, 2010.

Extends Payment Protections for Rural Providers – Extends Medicare payment protections to small rural hospitals, including hospital outpatient services, laboratory services, and facilities that have a low-volume of Medicare patients, but play an important role in their communities.

Imaging – Physicians must disclose ownership interest in imaging equipment to their patients.

Medicare Other

Cracking Down on Health Care Fraud – Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system by adding $250 million over 10-years.

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Physician Self-Referral (Specialty Hospitals) – Prohibits new/expanded physician ownership in hospitals, grandfathers physician-owned hospitals in operation as of December 31, 2010.

Medicare Part D (Prescription Drug Benefit) – Provides a $250 rebate for Part D enrollees who exceed the doughnut hole in 2010.

Strengthening the Quality Infrastructure – Additional resources provided to HHS to develop a national quality strategy and support quality measure development and endorsement for the Medicare, Medicaid, and CHIP quality improvement programs.

Medicaid

Medicaid Prescription Drug Coverage – Increases the Medicaid drug rebate from 15.1 percent to 23.1 percent of the average manufacturers price (AMP), and increases the drug rebate for generic drugs from 11 percent to 13 percent; and extends the drug rebate to include Medicaid managed care organizations.

Insurance Changes

Immediate Access to Insurance for Uninsured Individuals with a Pre-Existing Condition – Provides eligible individuals access to coverage that does not impose any coverage exclusions for pre-existing health conditions. This provision ends when exchanges are operational, effective 90 days from enactment.

Eliminating Pre-Existing Condition Exclusions for Children – Bars health insurance companies from imposing pre-existing condition exclusions on children's coverage, effective six months from enactment.

Prohibiting Rescissions — Prohibits abusive practices whereby health insurance companies rescind existing health insurance policies when a person gets sick as a way of avoiding covering the costs of enrollees' health care needs, effective six months from enactment.

Eliminating Lifetime Limits and Restricting Use of Annual Limits – Prohibits lifetime limits on benefits in all group health plans and in the individual market and prohibits the use of restrictive annual limits, effective six months from enactment.

Covering Preventive Health Services – All new group health plans and plans in the individual market must provide first dollar coverage for preventive services, effective six months from enactment.

Extending Dependent Coverage – Requires any group health plan or plan in the individual market that provides dependent coverage for children to continue to make that coverage available up to age 26, effective six months after enactment.

Bringing Down the Cost of Health Care Coverage – Health plans, including grandfathered plans, must annually report on the share of premium dollars spent on medical care and provide consumer rebates for excessive medical loss ratios (85 percent).

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Reducing the Cost of Covering Early Retirees – Creates a new temporary reinsurance program to help companies that provide early retiree health benefits for those ages 55-64 offset the expensive cost of that coverage.

Improving Consumer Assistance – Requires that any new group health plan or new plan in the individual market implement an effective appeals process for coverage determinations and claims.

Tax and Revenue Provisions

Small Business Tax Credit – Initiates the first phase of the small business tax credit for qualified small employers for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small nonprofit organizations.

Special Deduction for Blue Cross Blue Shield (BCBS) – Requires that non-profit BCBS organizations have a medical loss ratio of 85 percent or higher in order to take advantage of the special tax benefits provided to them under Internal Revenue Code (IRC) Section 833, including the deduction for 25 percent of claims and expenses and the 100 percent deduction for unearned premium reserves.

Non-Profit Hospitals – Establishes new requirements applicable to nonprofit hospitals beginning in 2010, including periodic community needs assessments every three years; implements a financial assistance policy; limits charges to certain patients to amounts generally billed to insured patients; and follow certain debt collection practices.

Tax Relief for Health Professionals with State Loan Repayment – Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas. This provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

Other

Strengthening Community Health Centers and the Primary Care Workforce – Provides funds to build new and expand existing community health centers, and expands funding for scholarships and loan repayments for primary care practitioners working in under served areas.

Encouraging Investment in New Therapies – A two-year temporary credit subject to an overall cap of $1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. The credit would be available for qualifying investments made in 2009 and 2010.

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Establishing a Patient-Centered Outcomes Research Institute – Establishes a private, non-profit institute to identify national priorities and provide for research to compare the effectiveness of health treatments and strategies.

Ensuring Medicaid Flexibility for States – A new option allowing States to cover parents and childless adults up to 133 percent of the Federal Poverty Level (FPL) and receive current law Federal Medical Assistance Percentage (FMAP) will take effect.

2011

Medicare Providers

Ambulatory Surgical Centers – Full productivity adjustment incorporated into annual update, and HHS to submit a value-based purchasing program plan to Congress by January 1, 2011.

Clinical Laboratory Services – Payments reduced 1.75 percent from 2011-2015.

Durable Medical Equipment – Productivity adjustment incorporated into the annual update.

Home Health – Market basket update reduced 1.0 percent for 2011-2013; and HHS to submit a value-based purchasing implementation program to Congress by October 1, 2011.

Imaging –Increases the utilization rate assumption for calculating the payment for advanced imaging equipment from 50 percent to 75 percent.

Medicare Other

Improving Health Care Quality and Efficiency – Establishes a new Center for Medicare & Medicaid Innovation to test innovative payment and service delivery models to reduce health care costs and enhance the quality of care provided to individuals.

Transitioning to Reformed Payments in Medicare Advantage – Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels to begin transition. Reduces Medicare Advantage benchmarks in subsequent years relative to current levels. Benchmarks will vary from 95 percent of Medicare spending in high-cost areas to 115 percent of Medicare spending in low-cost areas. Changes are phased-in over 3, 5 or 7 years, depending on the level of payment reductions.

Discounts in the Part D "Donut Hole" – Provides a 50 percent discount on all brand-name drugs in the donut hole and begins phasing in additional discounts on brand-name and generic drugs to completely close the donut hole by 2020 for all Part D enrollees.

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Increasing Training Support for Primary Care – Establishes a Graduate Medical Education policy allowing unused training slots to be re-distributed for purposes of increasing primary care training at other sites.

Improving Preventive Health Coverage – Provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and requires new plans to cover preventive services with little to no cost sharing. Creates incentives for State Medicaid programs to cover evidence-based preventive services with no cost-sharing, and requires coverage of tobacco cessation services for pregnant women.

Improving Transitional Care for Medicare Beneficiaries – Establishes the Community Care Transitions Program to provide transition services to high-risk Medicare beneficiaries.

Expanding Primary Care, Nursing, and Public Health Workforce – Increases access to primary care by adjusting the Medicare Graduate Medical Education program. Primary care and nurse training programs are also expanded to increase the size of the primary care and nursing workforce.

Medicaid

Increasing Access to Home and Community Based Services – The new Community First Choice Option, which allows States to offer home and community based services to disabled individuals through Medicaid rather than institutional care, takes effect on October 1, 2011.

Insurance Changes

Improving Consumer Assistance -- Requires the Secretary of Health and Human Services (HHS) to award grants to States to establish health insurance consumer assistance or ombudsman programs to receive and respond to inquiries and complaints concerning health insurance coverage.

Tax and Revenue Provisions

Reporting Health Coverage Costs on Form W-2 – Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

Standardizing the Definition of Qualified Medical Expenses – Conforms the definition of qualified medical expenses for Health Savings Accounts, Flexible Savings Accounts, and Health Retirement Accounts to the definition used for the itemized deduction. An exception to this rule is included so that amounts paid for over-the-counter medicine with a prescription still qualify as medical expenses.

Increased Additional Tax for Withdrawals from Health Savings Accounts and Archer Medical Savings Account Funds for Non-Qualified Medical Expenses – Increases the additional tax for HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses will increase from 15 to 20 percent.

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Cafeteria Plan Changes – Creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees.

Pharmaceutical Manufacturers Fee –Imposes an annual, non-deductible fee on the pharmaceutical manufacturing industry allocated according to market share and not applying to companies with sales of branded pharmaceuticals of $5 million or less as follows as follows: $2.5 billion in 2011, $3 billion in 2012-2016, $3.5 billion in 2017, $4.2 billion in 2018, and $2.8 billion in 2019 and beyond.

2012

Medicare Providers

Hospitals (Inpatient & Outpatient) – Full productivity reduction applies to annual update.

***Skilled Nursing Facilities (SNFs)* –** Productivity adjustment incorporated into annual update: HHS to develop and submit a value-based purchasing implementation program to Congress by October 1, 2011; and implementation of the RUG-IV classification system may not occur prior to October 1, 2011.

Long-Term Care Hospitals (LTCHs) – Productivity adjustment incorporated into annual update.

ESRD – Productivity adjustment incorporated into annual update; GAO to study the impact of including specified oral drugs in the bundled ESRD PPS on Medicare beneficiary access to high-quality dialysis services

Inpatient Rehabilitation Facilities (IRFs) – Productivity adjustment incorporated into annual update.

Medicare Other

Encouraging Integrated Health Systems – Implements physician payment reforms that enhance payment for primary care services and encourage physicians to join together to form “accountable care organizations” to gain efficiencies and improve quality.

Linking Payment to Quality Outcomes – Establishes a hospital value-based purchasing program to incentivize enhanced quality outcomes for acute care hospitals. Also, requires the Secretary to submit a plan to Congress by 2012 on how to move home health and nursing home providers into a value based purchasing payment system.

Reducing Avoidable Hospital Readmissions – Directs CMS to track hospital readmission rates for certain high-volume or high-cost conditions and uses new financial incentives to encourage hospitals to undertake reforms needed to reduce preventable readmissions, which will improve care for beneficiaries and rein in unnecessary health care spending.

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2013

Medicare Providers

Hospital Inpatient – Inpatient hospital Value Based Purchasing (VBP) program would transition from pay-for-reporting to pay-for-performance; and reduced payments to hospitals with high readmission rates begins. Under this program, a percentage of hospital payment would be tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical and pneumonia care.

Hospice – FY 2013-2019 market basket update reduced 0.3 percent; productivity adjustment incorporated into annual update; and HHS, in consultation with MedPAC, to revise the payment system.

Encouraging Provider Collaboration (Bundling) – Establishes a national pilot program on payment bundling to encourage hospitals, doctors, and post-acute care providers to work together to achieve savings for Medicare through increased collaboration and improved coordination of patient care.

Insurance Changes

Administrative Simplification – Health plans must adopt and implement uniform standards and business rules for the electronic exchange of health information to reduce paperwork and administrative burdens and costs.

Tax and Revenue Provisions

Limiting Health Flexible Savings Account Contributions – Limits the amount of contributions to health FSAs to $2,500 per year, indexed by CPI for subsequent years.

Eliminating Deduction for Employer Part D Subsidy – Eliminates the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees.

Increased Threshold for Claiming Itemized Deduction for Medical Expenses – Increases the income threshold for claiming the itemized deduction for medical expenses from 7.5 to 10 percent. Individuals over 65 would be able to claim the itemized deduction for medical expenses at 7.5 percent of adjusted gross income through 2016.

Additional Hospital Insurance Tax for High Wage Workers – Increases the hospital insurance tax rate by 0.9 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married filing jointly); and expands the taxable base to include net investment income in the case of taxpayers earning over $200,000 ($250,000 for joint returns).

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Medical Device Excise Tax – Establishes a 2.9 percent excise tax on the first sale for use of a medical device. Excepted from the tax are class I devices, eye glasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use.

Limiting Executive Compensation – Limits the deductibility of executive compensation under Section 162(m) for insurance providers if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements. The deduction is limited to $500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services, for or on behalf of, a covered health insurance provider. This provision is effective beginning in 2013 with respect to services performed after 2009.

2014

Medicare Provider

Quality Reporting for Certain Providers – Places certain providers – including ambulatory surgical centers, long-term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, PPS-exempt cancer hospitals and hospice providers – on a path toward value-based purchasing by requiring the Secretary to implement quality measure reporting programs in these areas and also pilot test value-based purchasing for each of these providers in subsequent years (see below).

Home Health – HHS directed to rebase payments, with a four-year transition, (payment reductions limited to 3.5 percent annually)

Hospice -- Quality reporting program established with a 2.0 percent penalty for failing to report.

Long-Term Care Hospitals (LTCHs) – Quality reporting program established with a 2.0 penalty for failing to report.

Inpatient Rehabilitation Facilities (IRFs) – Quality reporting program established with a 2.0 percent penalty for failing to report.

Medicare DSH Payments – Medicare DSH payments would be reduced as the number of uninsured patients is reduced.

Medicare Advantage – Requires 85 percent Medical Loss Ratio for MA plans; (failure to achieve will result in a rebate paid to HHS.

Medicaid

Increasing Access to Medicaid – Medicaid eligibility will increase to 133 percent of poverty for all non-elderly individuals to ensure that people obtain affordable health care in the most efficient and

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appropriate manner. States will receive increased federal funding to cover these new populations. Strikes the provision for a permanent 100 percent federal matching rate for Nebraska for the Medicaid costs of newly eligible individuals. Provides federal Medicaid matching payments for the costs of services to newly eligible individuals at the following rates in all states except expansion states: 100 percent in 2014, 2015, and 2016; 95 percent in 2017; 94 percent in 2018; 93 percent in 2019; and 90 percent thereafter.

Insurance Changes [2014 is the real start of expanding coverage]

Establishing Health Insurance Exchanges – Opens health insurance Exchanges in each State to individuals and small employers. This new venue will enable people to comparison shop for standardized health packages. It facilitates enrollment and administers tax credits so that people of all incomes can obtain affordable coverage.

Reforming Health Insurance Regulations – Implements strong health insurance reforms that prohibit insurance companies from engaging in discriminatory practices that enable them to refuse to sell or renew policies due to an individual's health status. Health plans can no longer exclude coverage for treatments based on pre-existing health conditions. It also limits the ability of insurance companies to charge higher rates due to heath status, gender, or other factors. Premiums can vary only on age (no more than 3:1), geography, family size, and tobacco use.

Eliminating Annual Limits – Prohibits health plans from imposing annual limits on the amount of coverage an individual may receive.

Ensuring Coverage for Individuals Participating in Clinical Trials – Prohibits new health plans from dropping coverage because an individual chooses to participate in a clinical trial and from denying coverage for routine care that they would otherwise provide just because an individual is enrolled in a clinical trial. Applies to all clinical trials that treat cancer or other life-threatening diseases.

Ensuring Choice through a Multi-State Option – Provides a choice of coverage through a multi-State plan, available from nationwide health plans under the supervision of the Office of Personnel Management.

Tax and Revenue Provisions

Promoting Individual Responsibility – Requires most individuals to obtain acceptable health insurance coverage or pay a penalty of $95 for 2014, $325 for 2015, $695 for 2016 (or, up to 2.5 percent of income in 2016), up to a cap of the national average bronze plan premium. Families will pay half the amount for children, up to a cap of up to a cap of $2,250 per family. After 2016, dollar amounts are indexed. If affordable coverage is not available to an individual, they will not be penalized.

Promoting Employer Responsibility – Requires employers with 50 or more employees who do not offer coverage to their employees to pay $2,000 annually for each full-time employee over the first 30 as long as one of their employees receives a tax credit. Precludes waiting periods over 90 days to become eligible

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for care. Requires employers who offer coverage but whose employees receive tax credits to pay $3,000 for each worker receiving a tax credit up to an aggregate cap of $2000 per full-time employee.

Providing Health Care Tax Credits – Makes premium tax credits available through the Exchange to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400 percent of poverty who are not eligible for or offered other acceptable coverage. They apply to both premiums and cost-sharing to ensure that no family faces bankruptcy due to medical expenses again.

Ensuring Choice through Free Choice Vouchers – Workers who qualify for an affordability exemption to the individual responsibility policy but do not qualify for tax credits can take their employer contribution and join an Exchange plan.

Small Business Tax Credit – Continues the second phase of the small business tax credit for qualified small employers.

Health Insurance Provider Fee – Imposes an annual, non-deductible fee on the health insurance sector allocated across the industry according to market share. The fee does not apply to companies whose net premiums written are $25 million or less.

2015

Medicare Providers

Hospital Inpatient – Hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a payment penalty.

Home Health – Productivity adjustment incorporated into annual update.

Continuing Innovation and Lower Health Costs – Establishes an ***Independent Payment Advisory Board*** to develop and submit proposals to Congress and the private sector aimed at extending the solvency of Medicare, lowering health care costs, improving health outcomes for patients, promoting quality and efficiency, and expanding access to evidence-based care. Commission proposals will be automatically implemented unless Congress acts in opposition.

Paying Physicians Based on Value Not Volume – Creates a physician value-based payment program to promote increased quality of care for Medicare beneficiaries.

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2016

Medicare Providers

Hospice – Pilot testing for value-based purchasing to occur no later than January 1, 2016

Long-Term Care Hospitals (LTCHs) – Pilot testing for value-based purchasing to occur no later than January 1, 2016.

Inpatient Rehabilitation Facilities (IRFs) – Pilot testing for value-based purchasing to occur no later than January 1, 2016.

2018

Tax and Revenue Provisions

Excise Tax – Excise tax on high cost (Cadillac) employer-provided health plans becomes effective. Tax is on the cost of coverage in excess of $27,500 (family coverage) and $10,200 (single coverage) increased to $30,950 (family) and $11,850 (single) for retirees and employees in high risk professions. The dollar thresholds are indexed with inflation, and employers with higher costs on account of the age or gender demographics of their employees may value their coverage using the age and gender demographics of a national risk pool.

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