

RATH YOUNG PIGNATELLI

Summary of Federal Health Care Reform Bill – April 15, 2010

HEALTH CARE REFORM BILL

TIMELINE OF CERTAIN KEY PROVISIONS

Effective January 1, 2010:

State Law Notification: Physicians must comply with new patient disclosure requirements for MRI, CT and PET services provided as in-office ancillary services. (See details below at Paragraph 4).

Medicare Claims Filing: The maximum period for submission of Medicare claims performed on or after January 1, 2010 is reduced to not more than 12 months.

Certification for DME & Home Health: Secretary may revoke enrollment for a period of not more than 1 year for each act by a physician or supplier who fails to maintain or does not provide access to documentation relating to written orders or requests for payment for DME, certifications for home health services or referrals for other items or services as specified by the Secretary. Physicians are required to have face-to-face encounters with patients prior to certification or re-certification for home health services or DME under Medicare.

Comparative Clinical Effectiveness: Establish a private, non-profit institute to identify national priorities and to provide research on comparative effectiveness of health treatments and strategies.

Small Business Tax Credits: First phase of small business tax credit (up to 35% of employer's contributions to health insurance for employees). Small employers can receive a credit for contributions to purchase health insurance for employees.

Effective in March, 2010:

HPSA Designations: Secretary, in consultation with stakeholders, must establish a comprehensive methodology and criteria for designating medically underserved populations and Health Professional Shortage Areas.

Fraud & Abuse:

Intent: Government will now be held to a lesser showing of intent in federal health care fraud cases, instead of a specific intent – now a general intent.

Enforcement: Medicare Administrative Contractors are allowed to perform additional reviews to limit fraud and abuse. Secretary may suspend Medicare and Medicaid payments to a provider or supplier pending an investigation of fraud. Health Care Fraud and Abuse Control program funding is increased by \$10 million each year for 10 years.

Overpayment Returns: Any person who knows of an overpayment is required to return the overpayment to the Secretary, the state or Medicare contractor within 60 days.

Sentencing: Sentences under federal sentencing guidelines are increased for health care fraud.

Statutory Expansion: The Anti Kickback Statute was amended to state that items and services resulting from AKS violations are false claims as well.

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The Healthcare Practice Group & Employment Practice Group provides a wide range of regulatory, corporate and litigation support to healthcare providers, employers and suppliers throughout New England and nationally.

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Background Checks: Secretary must establish a nationwide program for national and state background checks on direct patient access employees of certain long-term supports and services facilities or providers.

Non-Profits: Additional requirements established to qualify as a 501(c)(3) charitable hospital organization, including conducting a community needs assessment. (See details below at Paragraph 3).

Student Loans: Amounts received under any state loan repayment or loan forgiveness program intended to provide for increased availability of health care services in underserved or health professional shortage areas are excluded from gross income.

Effective April 1, 2010:

Voluntary Medicaid Expansion: States are allowed to cover parents and childless adults up to 133% of federal poverty level and an increase in the FMAP match.

Effective May 23, 2010:

High Risk Pool: Creation of a temporary federal high-risk pool for those who have been uninsured for 6 months and have a pre-existing condition.

Early Retiree Coverage: Creation of temporary reinsurance program to reimburse employers for part of the cost of providing health benefits to early retirees.

Effective September 23, 2010:

No Rescission: All individual and group plans are prohibited from rescinding a policy once enrolled except for fraud or intentional misrepresentations, and with prior notice to enrollee.

No Lifetime Limits/Restrictions on Annual Limits: All insurers are prohibited from imposing lifetime limits, and new individual and all group plans are prohibited from imposing unreasonable annual limits on benefits for all plans. Annual limits are prohibited beginning in 2014. New individual and group plans must cover preventive and wellness services and immunizations without cost-sharing.

Cover up to 26 Years Old: All individual and group plans must extend dependent coverage to individuals up to age 26 who are unmarried and not covered by another plan.

No Pre-existing Exclusions: Pre-existing conditions exclusions prohibited for dependents on all employer and new individual plans. (This will apply to adults in 2014).

Administration: Plans must implement effective appeal procedures. Non-discrimination rules will apply to fully insured plans.

Hospital Transparency: Hospitals are required to publicize a list of standard charges, including DRGs.

Stark Violation Disclosures: Secretary is required, within 180 days, to develop a mechanism for providers to voluntarily disclose specific information regarding actual and potential Stark violations.

Effective October 1, 2010:

Community Health Centers: Funds are provided to build new, and expand existing, community health centers.

Effective December 31, 2010:

No New Physician Owned Hospitals: Prohibition on physician ownership in hospitals that did not exist by agreement prior to December 31, 2010. Stark law whole hospital exception eliminated going forward.

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RAC Expansion: Not later than December 31, 2010, Recovery Audit Contractor program is expanded to Medicaid and Medicare Parts C and D. RACs are required to ensure that Medicare Advantage and Prescription Drug Plans implement anti-fraud plans.

Tanning Tax: Imposes 10% tax on amounts paid for indoor tanning services.

Effective January 1, 2011:

W-2 Reporting: Beginning in 2011, employers will be required to disclose the value of health coverage provided on Form W-2.

Bonus for Rural Doctors: Primary care providers and general surgeons practicing in health professional shortage areas are given 10% Medicare bonus payment for five years.

Insurer Transparency: Health plans must annually report on share of premium dollars spent on medical care.

Medical Loss Ratio: Institution of medical loss ratio requirements of 85% for large groups and 80% for small groups (with rebates to enrollees if medical spending is below this amount).

Medicare Wellness Visits: Coverage under Medicare is added for an annual wellness visit where individuals are provided personalized prevention plan services.

NPI Use Mandate: Secretary is required to promulgate a regulation no later than January 1, 2011 requiring all providers and suppliers that qualify for a national provider identifier to include the identifier on all applications for enrollment.

HSA Tax: The tax on HSA and Archer MSA withdrawals prior to age 65 that are used other than for qualified medical expenses is increased to 20 percent.

P.A. Scope of Practice: Physician assistants are authorized to order skilled nursing care services for Medicare beneficiaries beginning in 2011.

Rebates for Donut Hole: \$250 rebate check for Part D enrollees who enter the “donut hole.” In 2011, a 5% discount on brand-name drugs will be instituted and generic drug coverage will be provided in the donut hole. The gap will be filled by 2020.

Effective July 1, 2011:

Medicaid Never Events: Federal payments to states for Medicaid services related to Health Care-Acquired Conditions are prohibited.

Effective January 1, 2012:

ACO's: Secretary must establish a shared savings program that will reward Accountable Care Organizations that take responsibility for the costs and quality of care received by their patient panel. Pilot program to begin 2012. Shared savings payments made to ACOs for meeting quality performance and cost savings. May be limited to organizations with shared governance.

Quality of Care Payments: Secretary must establish value-based payment modifier that provides for differential payment to physicians and physician groups under fee schedule based on quality of care furnished compared to cost during a performance period.

Effective January 1, 2013:

Payroll Tax Increase: Increase in Medicare payroll tax rate of 0.9% for individuals earning over \$200,000 or couples earning over \$250,000. Tax is also expanded to include a 3.8% tax on net investment income in case of taxpayers earning over \$200,000 individually or \$250,000 as a couple.

Payment Reform: Establishment of 5-year national, voluntary pilot program on payment bundling for hospitals, physicians and post-acute care providers.

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Cafeteria Plan Contributions: Salary contributions to FSAs under a cafeteria plan are limited to \$2,500. However, the itemized deduction for medical expenses will increase to 10%.

Medicaid Increases: Medicaid payments for primary care services provided by a physician with a primary specialty designation of family medicine, general internal medicine or pediatric medicine will be reimbursed at 100% of payment rate that applies to such services under Medicare Part B in 2013 and 2014. 100% FMAP to states for meeting this requirement.

Effective March 31, 2013:

Medical Device Disclosures: On the 90th day of each year after this date, any covered drug, device, biological or medical supply manufacturer that provides payment or value to a physician or teaching hospital must report certain information to the Secretary for each preceding year. There will also be a 2.3% excise tax on the sale of medical devices.

Effective July 1, 2013:

Multi-State Plan Requirements: Secretary, in consultation with NAIC, must issue regulations on health care choice compacts, which will allow multiple states to enter into agreements allowing health plans to be offered in all compact states but be subject only to laws of state in which plan was written.

Administrative Simplification: Beginning in 2013, health plans must adopt and implement uniform standards for exchange of PHI.

Effective January 1, 2014:

Insurance Market Reforms: Imposition of annual fee on health insurers. Requires insurers to issue and renew policies regardless of health status. Eliminates pre-existing condition limitations; premium rates can only vary based on age (with a maximum 3:1 ratio); geography, family size and tobacco use; eliminates annual and lifetime benefit limits on essential benefits.

Exchanges: Secretary must set standards for establishment and operation of exchanges and qualified health plans; establishment of health insurance exchanges in each state for purchase of qualifying policies by individuals and small groups in accordance with standards; transitional reinsurance program created for 2014, 2015 and 2016, which requires states to contract with nonprofit reinsurance entity that is funded by fees collected from insurers and provides payments to insurers covering high-risk individuals.

Individual Mandate and Credits: Requires most uninsured individuals to obtain insurance or pay penalty (\$95 in 2014, \$325 in 2015, \$695 or 2.5% of income in 2016 and indexed thereafter (with caps on penalties based on the cost of the lowest tier exchange plans). Tax credits are available for individuals and families above Medicaid eligibility and below 400% of federal poverty standard and reduced cost sharing for individuals and families between 100% and 400% of federal poverty standard.

Employer Mandate: Employers with 50 or more employees that do not offer coverage must pay \$2,000 annually for each full-time employee in excess of 30 employees, as long as at least one employee received premium assistance tax credits. If employer does offer coverage but has at least one employee receiving the premium assistance tax credit, the employer must pay \$3,000 for each employee receiving the tax credit up to an aggregate cap of \$2,000 per employee.

Increasing Medicaid Access: Medicaid eligibility increases to 133% of federal poverty level of all non-elderly individuals; the federal government will pay 100% of cost of covering newly eligible individuals for 2014, 2015 and 2016.

Presumptive Eligibility: All hospitals that participate in Medicaid are permitted to make presumptive eligibility determinations.

DSH Reductions: DSH Medicaid payment reductions apply to states beginning in FY 2014; Medicare DSH payments are reduced as the number of uninsured patients is reduced, effective FY 2014.

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Hospital Pay for Performance: Beginning in 2013, hospitals will have 1% withholds, phased up to 2% in 2017 and beyond; CMS will evaluate reporting programs and pay for performance phased in for LTCHs, IRFs, hospice, cancer hospitals and inpatient psych hospitals.

Effective January 15, 2014:

Payment Advisory Panel: A 15-member Independent Payment Advisory Board tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. Beginning in 2020, the Independent Payment Advisory Board is required to make binding biennial recommendations to Congress if the growth rate in overall health spending exceeds the growth in Medicare spending; such recommendations would focus on slowing overall health spending while maintaining or enhancing beneficiary access to quality care under Medicare. Hospitals and hospice exempt through 2019.

Effective January 1, 2017:

Large Group Exchanges: States are allowed to permit large group coverage to be offered through exchanges.
Medicaid Expansion Support: Federal government support for Medicaid expansion of 95% of additional costs in 2017. Federal government support for Medicaid expansion of 94% of additional costs in 2018. Federal government support for Medicaid expansion of 93% of additional costs in 2019.

Effective January 1, 2018:

Excise Tax on “Cadillac Plans”: Excise tax is imposed on insurers if aggregate value of employer-sponsored health coverage per employee exceeds certain thresholds.

SOURCES OF REVENUE/MEDICARE AND MEDICAID REDUCTIONS

A. Sources of Revenue:

<u>Source of Revenue</u>	<u>10 Year Impact from Source</u> ¹ (eff. date of implementing provision)
Medicare payroll tax increases	\$210 B (2013)
Industry fee on health insurers	\$60 B (2014)
Other/non-healthcare revisions	\$47 B
40% excise tax on high cost health plans	\$32 B (2018)
Industry fee on drug companies	\$27 B (2011)
2.3% excise tax on medical devices	\$20 B (2013)
Increase floor on medical expense deductibility (to 10%)	\$15 B (2013)
Limit FSAs to \$2,500	\$13 B (2013)
Revise definition of HSA/MSA expenses	\$5 B (2011)
Eliminate deduction for drug benefit subsidies	\$4.5 B (2013)
10% excise tax on indoor tanning	\$2.7 B (2010)
Increase tax on non-medical HSA distributions	\$1.4 B (2011)

¹ 10-year estimates from Bank of America Merrill Lynch

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B. Medicare/Medicaid Reductions:

Reduction Provision ²	10 Year Impact of Reduction ¹ (eff. date of implementing provision)
Medicare provider MB reductions	\$157 B (2010)
Medicare Advantage payment reductions	\$136 B (2011)
Medicare Advantage interaction with FFS cuts	\$70 B (2012)
Medicare home health payment reforms/cuts	\$40 B (2011)
Medicaid drug rebate increases	\$38 B (2010)
Adjustment in calculation of Part B premiums	\$25 B (2011)
Medicare DSH reductions	\$22 B (2014)
Independent payment advisory board	\$16 B (2015)
Medicaid DSH reductions	\$14 B (2014)
Part D premium increases for high income	\$11 B (2011)
Follow-on biologics	\$7 B (2014)
Hospital readmission reductions	\$7 B (2013)
LTC pharmacy utilization reductions	\$5.7 B (2012)
Medicare imaging reforms	\$2.3 B (2011)

COBRA EXTENSION

The U.S. Department of Labor has again updated model notice packages for group health plans and employers to provide appropriate notice on COBRA coverage premium reductions available through March 31, 2010. To qualify for the 35% subsidy of eligible individual COBRA premiums, individuals must experience a COBRA qualifying event that is the involuntary termination of a covered employee's employment. The involuntary termination must occur during the period that began September 1, 2008 and now ends on March 31, 2010. In addition, an involuntary termination of employment that occurs on or after March 2, 2010 but by March 31, 2010 and follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008 through March 31, 2010, is also a qualifying event. Premium reduction applies to periods of health coverage that began on or after February 17, 2009 and last for up to 15 months.

² The provision closing the Medicare Part D "donut hole" adds an estimated \$43 B in costs over 10 years. This provision takes effect in 2010.

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