ABA HEALTH REFORM PODCAST

Andrew J. Demetriou
Former Chair, ABA Health Law Section and Chair, Task Force on Access to Healthcare
March 30, 2010

Welcome to the third in a series of podcasts on health care reform legislation produced by the American Bar Association Health Law Section, as a service to our members, other members of the Association and the general public. My name is Andrew Demetriou, and I am a former Chair of the Health Law Section and current Chair of our Task Force on Access to Health Care. None of the views or comments expressed represent the policy or views of the American Bar Association or any Section, Division or Forum, nor do they represent legal advice of the position of my law firm on any issue.

After a year of committee work, public debates and demonstrations, presidential lobbying and a national civics lesson courtesy of the United States Congress, we are on the brink of the most comprehensive change in the American healthcare system since the enactment of Medicare and Medicaid in 1965. The general public became acquainted with arcane legislative terms such as "reconciliation," "deem and pass," "votorama" and cloture. It was a field day for pundits, speculating on the effect of each proposal, committee hearing, special election and even the death of Congressman John Murtha. Healthcare reform was buried and resurrected more times than the proverbial cat. In this podcast I will outline the major elements of this legislation. The ABA Health Law Section will be producing a number of teleconferences in the upcoming weeks, providing insights into specific provisions of the laws in much greater detail and I hope you will join us for these programs.

The Senate bill, curiously numbered HR 3590 (to conform to the Constitutional requirement that bills concerning taxes originate in the House), known as the Patient Protection

and Affordable Care Act, was passed the Senate on Christmas Eve 2009 and by the House on March 21, 2010. It was signed by President Obama on March 23, 2010 in an East Room ceremony that featured 22 signing pens. Over 2700 pages long, it contains far reaching provisions aimed at reducing the number of Americans without health coverage by making insurance coverage affordable for the middle class and small employers through subsidies and tax credits, expanding eligibility for the federal Medicaid program, reforming insurance underwriting practices and eligibility standards and sponsoring a system of state-based insurance exchanges through which individual consumers and small employers can gain access to policies at better rates. In addition, the law contains significant changes to the Medicare system that are intended to slow the growth in federal healthcare expenditures over time by promoting efficiency in the delivery of services, reforming payment practices and reimbursement methodologies for providers, enhancing enforcement of fraud and abuse laws and changing the payment landscape for so-called Medicare Advantage plans for seniors. An important benefit for Medicare beneficiaries is a phased-in closing the "donut hole" in Medicare prescription drug coverage, which currently obligates seniors to pay 100% of the costs of drugs above $2700 until their expenditures exceed $4000.

The proposed expenditures to achieve enhanced coverage will be paid for by a variety of new taxes, including an increased Medicare tax on high income individuals, taxes on insurance premiums, new taxes on medical devices and an excise tax imposed on high cost "Cadillac" health plan benefits. In addition, the new law's cost estimates assume that reductions in federal outlays under the Medicare and Medicaid programs, primarily in payments to providers and Medicare Advantage plans over time will offset expenditures by roughly $500 billion over the next ten years. A critical component of this cost reduction effort is the creation of an

Independent Payments Advisory Board, which beginning in 2014, will be empowered to implement recommend changes in Medicare reimbursement and expenditures which can only be overriden by a Congressional vote.

Passage of the Senate bill by the House was highly controversial and in order to address the concerns of a number of House Democrats, the House passed a companion measure, HR 4872, the Budget Reconciliation Act of 2010, which was intended to amend several provisions in the new law. The Reconciliation Act was debated and passed by the Senate on March 25, thereby achieving the entirety of what emerged as a solely Democratic health reform plan. The Reconciliation Act has been sent to the President and is expected to be signed today, March 30, 2010.

To deal with the political realities of securing passage in a Senate with 41 Republicans, the House leadership was forced to abandon key provisions in a bill passed by the House in November 2009, including the governmentally run public health insurance option, a national (rather than state-based) insurance exchange, and the creation of a federal insurance czar with power to prescribe rules concerning premiums and medical loss ratios for health insurance carriers.

The most significant changes embodied in the legislation concern reform of the health insurance markets. Effective immediately, health insurers can no longer rescind coverage of individuals based on the discovery of an undisclosed health condition, children can no longer be excluded from coverage based on pre-existing health conditions and dependent children can remain covered by their parents' policies until age 26. The law also prohibits lifetime benefit caps and requires coverage of emergency services at in-network rates. Tax credits for qualifying

small employers to facilitate the purchase of insurance for their employees will also be available this year.

In 2014, a number of additional changes will take effect, including tax credits and subsidies for individuals with incomes up to 400% of the federal poverty line for the purchase of health insurance not otherwise provided through their employer. In addition, each state will establish an insurance exchange that will be open to individuals who are not covered by an employer plan and small employers. The exchanges will receive federal support payments and plans that are offered through the exchanges must meet certain criteria in terms of deductibles and co-payment obligations and set at difference premium levels. Insurance plans will not be able to discriminate in coverage decisions based on pre-existing health conditions for any individual, thus extending the protections available to those covered by group plans since the enactment of HIPAA in 1996 and may no longer impose annual caps on benefits payable.

In addition to the changes applicable to the private insurance markets, the health reform legislation will achieve a significant expansion in coverage through opening the Medicaid program to individuals with incomes up to 150% of the federal poverty level. In recognition of the need for expansion of primary care services to this population, the Reconciliation bill includes a provision that increases payments to primary care physicians to the same levels as provided in the Medicare program. In addition, the Reconciliation bill increases the level of federal support to the states in order to offset the increased costs due to expansion of the Medicaid covered population. Unlike the Senate bill, which included features derisively nicknamed “the Cornhusker kickback” and “the Louisiana Purchase” the Reconciliation bills treats all states the same for enhanced Medicaid support, but does not recognize existing disparities and coverage and cost due to variations in state coverage.

To achieve coverage objectives in the law, starting in 2014 individuals will be required to purchase health insurance and employers with over 25 employees will be required to provide coverage to their workforce. The individual mandate shall be enforced through a requirement that individuals provide evidence of coverage with their tax returns, or pay a penalty of a stipulated amount subject to income limitations. The employer mandate is modeled on the pay or play system adopted in Massachusetts in 2006. Employers that do not provide health insurance as a job benefit, with stipulated levels of employer contribution toward premiums, will be penalized based on the number of employees. The penalties are intended to provide funds to offset the costs associated with covering these individuals through government programs.

The law presupposes significant savings in the Medicare system over the next decade. The assumption is that these savings will be achieved through a variety of changes to payment mechanisms to promote efficiency, enhanced enforcement of anti-fraud laws as well as the agreement of hospitals and pharmaceutical manufacturers to accept significant cuts in projected Medicare reimbursement to offset the beneficial effect of the decrease in the uninsured population.

The law includes a mechanism in which an independent government body, the Independent Payments Advisory Board, would make periodic recommendations for revisions in payment schedules under Medicare. These proposals would have to be considered by the House and Senate as a package, in a manner similar to the legislation relating to the closure of military bases, and voted up or down. If Congress reverses a recommendation of the IPAB, a presidential veto of that legislation would have the effect of reinstating the recommendation.

The Medicare program will begin incorporate additional quality reporting requirements with bonuses to providers as well as wider scale, "value based purchasing," in which reimbursement will be linked to quality outcomes and efficiency in delivery of services. Research into comparative effectiveness of various medical procedures, conducted under the aegis of a new quasi-federal board (and presumably the Federal Coordinating Council created by the 2009 stimulus legislation) could be used in developing these new payment methodologies, but only when supported by other data. The law contains these fairly strict limitations on the use of research data as a result of a political compromise in response to the fatuous claims that the legislation would create federal "death panels." There are general prohibition on the use of comparative effectiveness research to limit coverage of procedures under federal health programs, to limit certain medical interventions to extend life on the basis that the treatments are better used for younger, healthier patients, or to evaluate treatments on the basis of a quality adjusted life year (a measure used by the National Health Service in the United Kingdom) to determine whether a medical expenditure is appropriate in view of the likelihood that it will extend life. These limitations will create hurdles to the implementation of evidence based practices into federal health programs. Nonetheless, the resulting medical research should prove valuable to clinicians and potentially could be adopted by private health plans in advance of the government.

The federal Centers for Medicare and Medicaid Services will be expected to explore additional bundled payment mechanisms for services related to particular diagnoses and expand demonstration projects on payment alternatives that promise to reward provider practices that promote healthy outcomes and efficiency rather than merely providing more services. This may include demonstrations of capitated payment systems and the enhanced development of so-called

"Accountable Care Organizations" in which providers cooperate to deliver services to defined populations within global health budgets.

A key issue which was not addressed in the legislation is the Sustainable Growth Rate formula for physician payments. The Medicare Payment Advisory Commission has recommend reductions in payments to physicians sufficient to ensure that the Medicare Trust Fund will have sufficient reserves to sustain itself over time. Historically, the Commission has recommended cuts, only to have the recommendation overridden by Congress through piecemeal legislation. Implementation of the SGR formula in 2010 would result in a 21% reduction in payments under Medicare Part B. The Senate had passed a temporary suspension of this cut, which expires March 31. The House had passed separate legislation that would provide a long term fix for this issue but the Senate has not considered a companion meausre. The CBO has estimated that replacement of the SGR formula with relatively flat to modest growth in physician payments will cost $247 billion over the next decade and there is no doubt that the magnitude of this commitment has concerned members of Congress.

As noted, the law contains a phased-in process for closing the so-called "donut hole" in reimbursement under the Medicare prescription drug benefit. In part, the legislation contemplates that individuals will receive significant discounts on drug purchases that exceed the primary threshold for coverage ($2700 per beneficiary). These discounts are a product of the roughly $80 billion in reimbursement concessions offered by the pharmaceutical industry in negotiations with the White House. In addition, the legislation provides a $250 tax credit effective in 2010, and escalating thereafter and contemplates subsidies to low income seniors to defray costs in excess of the threshold.

The new law will make significant changes in payments to private insurance plans that provide benefits to enrollees under the Medicare Advantage Program, primarily by revamping the bidding process by which these plans are selected to participate in Medicare Advantage and adjustments to the payment methodologies. According to the CBO, the net effect will be a reduction of perhaps as much as $150 billion in Medicare payments to these plans over the next ten years. There has been considerable speculation about whether the new requirements and proposed reductions in payments will discourage private plans from participating in Medicare Advantage, thus causing a shift back to traditional Medicare for a significant cohort of seniors.

The legislation will mandate changes in Medicare payment methodologies to promote accuracy, through reevaluation of payment principles for various services. For example, home health payments would be rebased to better take into account the acuity of patient conditions and this is estimated to reduce home health payments by over $30 billion in the next decade. The Relative Value Units, or RVUs, that define levels of physician compensation under Medicare Part B would be regularly reviewed and revised as well as Hospital Wage Indices that affect federal payments for hospital services under Medicare Part A. These changes are expected to contribute to cost savings over time by reducing payments for some services and altering physician and provider behavior.

The reform legislation will continue the trend of the past few years of increasing enforcement budgets for agencies that investigate and prosecute fraud and abuse cases involving federal health programs. Combined with recently passed revisions to the false claims act, many lawyers expect an increase in prosecutions. There will be new requirements concerning disclosure by physicians of referrals that may implicate the anti-kickback and Stark laws. In addition, the whole hospital exception for physician ownership will be restricted to existing

levels of physician ownership of hospitals and the licensed bed levels of physician-owned hospitals as of March 23, 2010 and no physician-owned hospital will be exempt from the Stark law if it does not have a provider agreement in place by December 31, 2010.

The law will create incentives to expand the number of primary care physicians (through Graduate Medical Education payments and bonuses under Medicare) and nurses. Medicare payment systems will be revised to promote primary care services. New programs to promote wellness and preventive care will be eligible for incentives. Demonstration projects will be supported to enhance primary care and general surgical services. Finally the law will require that all insurance plans provide for parity in coverage between mental health benefits and other services.

Financing the expenditures under the legislation will require that hundreds of billions of dollars be raised through new taxes in order to offset the anticipated costs of subsidies, tax credits, Medicaid expansion and other outlays. Some of these revenues will come from new taxes on pharmaceutical companies, device manufacturers and health insurance plans that will phased in over several years. The tanning industry was singled out for a special tax that is expected to raise $10 billion over the next decade. Additional revenues will come from penalties applicable to employer and individual coverage mandates as well as changes in tax laws affecting funds in health savings accounts and limits on deductibility of medical expenses. Finally, some new taxes will be imposed on Medicare beneficiaries based on income.

A key provision in the Senate bill was a new tax on so-called “Cadillac” benefit plans. This tax would have applied to insurance companies that write policies that provide benefits with a value in excess of $8,500 for individuals and $23,000 for families commencing in 2013. For

individuals in certain high-risk occupations, such as firefighters, the levels were adjusted upward. The employer is responsible for calculating the applicable taxable portion of benefits and allocation as between multiple carriers in the event that health benefits involve different medical and dental plans. The tax will apply to employers and administrators in the case of employer self-funded benefit plans, including employer sponsored Health Savings Accounts. The tax will be a non-deductible excise tax.

The Reconciliation bill included changes to this tax that were the product of negotiation between the White House and labor leaders, who were concerned that the tax would heavily on union negotiated benefit plans and that the costs associated with the tax would be passed through to beneficiaries through higher premiums or changes in benefits in the future. As a result, the levels at which the tax will apply were raised to $10,200 for individuals and $27,500 for families and would take effect until 2018. These levels will be subject to adjustment upward based on changes in certain benchmark premium levels.

To accommodate the reductions in revenues from changes to the Cadillac benefits tax the Senate had included an increase in the level of the so-called Medicare tax on payroll income to 2.35% for individuals and a comparable rate on employers for income in excess of $250,000 for joint filers and $200,000 for all others. The Reconciliation bill added an additional new tax of 3.8.% on certain defined investment and other passive income for high income taxpayers. An important aspect of both of these taxes is that the levels at which the taxes apply are not indexed, meaning that an increasing number of taxpayers will become subject to these taxes in the future.

A final point is that immediately upon signing of the Patient Protection and Affordable Care Act, 13 Republican Attorneys General filed suit in Pensacola, Florida, challenging the

constitutionality of the law. The two major arguments advanced by the Attorneys General are that the individual mandate to purchase insurance represents an unconstitutional exercise of Congressional power under the Commerce Clause and that the penalties for non-compliance are not taxes permitted under Article I of the Constitution or income taxes authorized by the 16th Amendment. There has been considerable academic discussion on the merits of this case, with responsible opinion expressed on each side of the issues. It is almost certain that this dispute will ultimately be resolved by the Supreme Court, especially since the key challenged provisions will not take effect until January 1, 2014.

The Patient Protection and Affordable Care Act represents a significant change in the financing of health care benefits for many Americans, although its full effects will not be seen for many years. It also promises some changes in the delivery of health services, but the impact of these changes is far more speculative as it rests on a number of demonstration projects and changes that may be expanded or phased in over a long term. It is difficult to assess the ultimate costs of these changes, because the CBO estimates of cost were highly qualified and in some areas, admittedly incomplete. Nonetheless, the new law enlarges the federal role in the healthcare economy and its ultimate fate and impact on society may depend on the expression of public reaction to the thrust of law, as reflected in the landscape of elected officials who will be charged with determining the future of this legislation.