

THE LEGISLATIVE BULLETIN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

Week of March 29, 2010

Contact Us

P.O. Box 1457
Montpelier, Vermont 05601
Toll-Free: 800-640-8767
Fax: 802-223-1201
Online at: www.vtmd.org

Working for Vermont Physicians at the State House

Paul Harrington
Executive Vice President
pharrington@vtmd.org

Madeline Mongan
Deputy Exec. Vice Pres.
mmongan@vtmd.org

Stephanie Winters
Operations Director
swinters@vtmd.org

In This Issue:

Pages 1-4
**Comprehensive Health
Care Reform Becomes
Law**

Pg. 2
**Senate Fails to Prevent
21.3 Percent Medicare
Reimbursement Cut**

COMPREHENSIVE HEALTH CARE REFORM BECOMES LAW

On March 23, 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act, into law. According to the Congressional Budget Office, the \$938 billion bill reduce the federal deficit by \$143 billion over a decade.

Together, the reconciliation package and the health care legislation are expected to cover an additional 32 million Americans by 2019, boosting the percentage of non-elderly Americans with insurance to 94 percent from the current rate of 83 percent. The legislation also establishes a broad new framework of government regulation to prevent insurance companies from denying coverage to people who are sick and to require insurers to provide a minimum level of benefits.

Reform Legislation Boosts Vermont Medicare Reimbursement Rates

The Vermont Medical Society has consistently measured the degree to which the state's physicians are "discriminated against" by Medicare reimbursement by determining how far the state is from a midpoint of two geographic adjusters (GPCI) under the RBRVS payment formula: the physician work component and the practice expense component.

If the health reform legislation had not become law, Vermont physicians would have received 95.604 percent of the midpoint. However, since the legislation has become law retroactive to Jan. 1, 2010, Vermont Medicare reimbursements will be 97.676 percent of the midpoint of the two geographic adjusters.

Therefore, as a direct result of VMS's work with other state societies to achieve geographic equality, Vermont physicians will receive an additional 2.07 percent in Medicare payments. In 2007, Medicare payments to Vermont physicians were approximately \$110 million, so this change will result in an additional \$2.2 million in revenue.

When Will Key Provisions Go Into Effect?

The following timeline provides implementation dates for key provisions. It reflects provisions in the new law and incorporates modifications to the law included in the Health Care and Education Reconciliation Act of 2010 passed by the House and the Senate on March 25, 2010.

2010

Insurance Reforms

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that provide health insurance for employees.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)

Continued on Page 2

HEALTH CARE REFORM

Con'td from pg. 1

- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs.
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases.

Medicare

- Provide a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.

Quality Improvement

- Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.

Workforce

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.
- Establish Teaching Health Centers to provide Medicare payments for primary care residency programs in federally qualified health centers.

2011

Long-term Care

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

- Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare; increase Medicare payments for certain preventive services to 100 percent of actual charges or fee schedule rates.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

- Require pharmaceutical manufacturers to provide a 50

SENATE FAILS TO PREVENT 21.3 PERCENT MEDICARE REIMBURSEMENT CUT FROM TAKING PLACE ON APRIL 1

Late last week the U.S. Senate failed to authorize a 30-day extension of current Medicare physician payment rates that would have postpone once again a 21.3 percent cut in reimbursements. In a replay of the standoff that occurred a month ago Senator Tom Coburn, M.D. (R-OK) objected to the bill on the basis that it should not be considered emergency spending that would be exempt from budgetary offsets. As a result, Congress adjourned for its two-week spring recess without taking action to stop these programs from expiring. VMS has been informed that the Senate plans to hold a cloture vote after the recess which, if supported by 60 Senators, will allow a vote to occur on the legislation. That vote could occur as early as April 12.

The Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other providers of services paid under the Medicare Physician Fee Schedule (MPFS). As you are aware, the Temporary Extension Act of 2010, enacted on March 2, 2010, extended the zero percent (0 percent) update to the 2010 MPFS through March 31, 2010.

CMS believes Congress is working to avert the negative update that will take effect April 1. Consequently, CMS has instructed its contractors to hold claims containing services paid under the MPFS (including anesthesia services) for the first 10 business days of April. This hold will only affect claims with dates of service April 1, 2010, and forward. In addition, the hold should have minimum impact on provider cash flow because, under the current law, clean electronic claims are not paid any sooner than 14 calendar days (29 for paper claims) after the date of receipt.

Be on the alert for more information about the 2010 Medicare Physician Fee Schedule Update.

HEALTH CARE REFORM

Cont'd from pg. 2

percent discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.

- Provide a 10 percent Medicare bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)

Medicaid

- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90 percent FMAP for two years.

Quality Improvement

- Establish a new trauma center program to strengthen emergency department and trauma center capacity.
- Improve access to care by increasing funding by \$11 billion for community health centers and the National Health Service Corps over five years.

2012

Medicare

- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.

Medicaid

- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016).

2013

Insurance Reforms

- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter

information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. (Effective April 1, 2014)

Medicare

- Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25 percent in 2020, in addition to the 50% manufacturer brand-name discount).
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Medicaid

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100 percent federal funding.

Quality Improvement

- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Tax Changes

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5 percent of adjusted gross income to 10 percent of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.
- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9 percent (from 1.45 percent to 2.35 percent) on earnings over \$200,000 for individual taxpayers and
- \$250,000 for married couples filing jointly and impose a 3.8 percent assessment on unearned income for higher-income taxpayers.
- Limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3 percent on the sale of any taxable medical device.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

Continued on Page 4

HEALTH CARE REFORM

(Cont'd from pg. 3)

2014

Individual and Employer Requirements

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer.

Insurance Reforms

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the exchanges.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60 percent of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan.
- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
- Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200 percent FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)
- Create a temporary reinsurance program to collect payments from health insurers in the individual and

group markets to provide payments to plans in the individual market that cover high-risk individuals.

- Require qualified health plans to meet new operating standards and reporting requirements.

Premium Subsidies

- Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400 percent FPL to purchase insurance through the Exchanges.

Medicare

- Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019);
- Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. (Issue recommendations beginning January 2014).
- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75 percent and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided.

Medicaid

- Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133 percent FPL based on modified adjusted gross income (MAGI).
- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments.

Prevention/Wellness

- Permit employers to offer employees rewards of up to 30 percent, increasing to 50 percent if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards.

2015 and later

Medicare

- Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1 percent. (Effective fiscal year 2015)

Tax Changes

- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. (Effective January 1, 2018).

For additional info., please go to: <http://healthreform.kff.org/>