



# Health Care *Alert*

Health Care Tax alert

---

March 19, 2010

## House Democrats Release Health Care Reform Reconciliation Bill with Cost of \$940 Billion

House Democrats have released their health care reform reconciliation bill – the ***Reconciliation Act of 2010*** (H.R. 4872) with a projected 10-year cost of \$940 billion would result in coverage to some 32 million uninsured when coupled with the Senate’s ***Patient Protection and Affordable Care Act*** (HR 3590). The reconciliation bill is scheduled to be considered March 21. A [copy](#) of the 153 page legislative text is available on the House Rule’s Committee website.

It is anticipated that the House will vote to accept HR 3590 and its reconciliation bill. The Senate would have to vote on the House’s Reconciliation Bill with the need for only a simple 51 vote majority for passage.

The reconciliation bill contains changes including increased tax credits to help people buy insurance, more federal funding to states for Medicaid, thereby rescinding the favorable treatment for Nebraska, closure of the Medicare prescription-drug doughnut hole, 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, which in turn reduces the revenue it could have raised to a total of only \$32 billion over a decade, leaving a \$116 billion hole that has been filled by extending the Medicare payroll tax to unearned income for joint filers earning \$250,000 or more and individuals making \$200,000 and up.

The following is a section-by-section analysis based on material *Prepared by Committees on Ways & Means, Energy & Commerce, and Education & Labor, March 18, 2010, and from the legislative text.*

**Title I – Coverage, Medicare, Medicaid and Revenues**

***Subtitle A – Coverage***

**Sec. 1001 – Affordability.** Improves the financing for premiums and cost sharing for individuals with incomes up to 400 percent of the federal poverty level.

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 133%	2.00%	2.00%
133% up to 150%	3.00%	4.00%
150% up to 200%	4.00%	6.30%
200% up to 250%	6.30%	8.05%
250% up to 300%	8.05%	9.50%
300% up to 400%	9.50%	9.50%

**Sec. 1002 – Individual responsibility.** Modifies the assessment that individuals who choose to remain uninsured pay in three ways:

- (a) Exempts the income below the filing threshold,
- (b) Lowers the flat payment from \$495 to \$325 in 2015 and from \$750 to \$695 in 2016, and
- (c) Raises the percent of income that is an alternative payment amount from 0.5 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 to make the assessment more progressive.

**Sec. 1003 – Employer responsibility.** Improves the transition to the employer responsibility policy for employers with 50 or more full-time equivalent workers (FTE) by subtracting the first 30 full time employees from the payment calculation (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). The provision also changes the applicable payment amount for firms with more than 50 FTEs that do not offer coverage to \$2,000 per full-time employee. It also eliminates the assessment for workers in a waiting period, while maintaining the 90-day limit on the length of any waiting period beginning in 2014.

**Sec. 1004 – Income definitions.** Modifies the definition of income that is used for purposes of subsidy eligibility and the individual responsibility requirement. The modifications conform the income definition to information that is currently reported on the Form 1040 and to the present law income tax return filing thresholds. The provision also extends the exclusion from gross income for employer provided health coverage for adult children up to age 26.  
**Sec. 1005 – Implementation funding.** Provides \$1 billion to the

Secretary of Health and Human Services to finance the administrative costs of implementing health insurance reform.

### ***Subtitle B – Medicare***

**Sec. 1101 – Closing the Medicare prescription drug “donut hole”.** Provides a \$250 rebate for all Medicare Part D enrollees who enter the donut hole in 2010. 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.

**Sec. 1102 – Medicare Advantage payments.** Freezes Medicare Advantage payments in 2011. Beginning in 2012, the provision reduces Medicare Advantage benchmarks 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. The changes will be phased-in over three, five or seven years, depending on the level of payment reductions. The provision creates an incentive system to increase payments to high quality plans by at least 5 percent. It also extends CMS authority to adjust risk scores in Medicare Advantage for observed differences in coding patterns relative to fee-for-service.

**Sec. 1103 – Savings from limits on MA plan administrative costs.** Ensures Medicare Advantage plans spend at least 85 percent of revenue on medical costs or activities that improve quality of care, rather than profit and overhead.

**Sec. 1104 – Disproportionate share hospital (DSH) payments.** Advances Medicare disproportionate share hospital cuts to begin in fiscal year 2014 but lowers the ten-year reduction by \$3 billion.

### ***Comment***

This would be accomplished by substituting the Senate's minus 1.5 percentage points and inserting minus 0.1 percentage points for fiscal year 2014 and minus 0.2 percentage points for each of fiscal years 2015, 2016, and 2017 and for each of 2018 and 2019, minus 1.5 percentage points.

**Sec. 1105 – Market basket updates.** Revises the hospital market basket reduction that is **in addition to the productivity adjustment** in the Senate Bill as follows: -0.3 percentage points in FY 2014 and -0.75 percentage points in FY 2017, FY 2018 and FY 2019. Removes Senate provision that eliminates the additional market basket for hospitals based on coverage levels. Providers affected are inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, psychiatric hospitals and outpatient hospitals.

**Comment**

This would be accomplished as follows: (Note all reductions would be a substitute to the Senate's Bill). Also, the reconciliation bill does not appear to prevent the overall increase from being a negative rate-of-increase.

*Inpatient PPS Hospitals:*

The reductions for fiscal year 2014 would be -0.3 percentage point; for each of fiscal years 2015 and 2016, -0.2 percentage point; and for each of fiscal years 2017, 2018, and 2019, by -0.75 percentage point.

*Long-term Care Hospitals:*

The reduction for rate year 2014 would be -0.3 percentage point; for each of rate years 2015 and 2016, -0.2 percentage point; and for each of rate years 2017, 2018, and 2019, by -0.75 percentage point.

*Inpatient Rehabilitation Facilities:*

The reduction for fiscal year 2014 would be -0.3 percentage point; for fiscal year 2014, -0.3 percentage point; for each of fiscal years 2015 and 2016, 0.2 percentage point; and for each of fiscal years 2017, 2018, and 2019, by -0.75 percentage point.

*Psychiatric Hospitals:*

The reduction for rate year 2014 would be -0.3 percentage point; for each of the rate years beginning in 2015 and 2016, -0.2 percentage point; and for each of the rate years beginning in 2017, 2018, and 2019, by -0.75 percentage point.

*Outpatient Hospitals:*

The reduction for calendar year 2014 would 0.3 percentage point; for each of 2015 and 2016, 0.2 percentage point; and for each of 2017, 2018, and 2019, by -0.75 percentage point.

**Sec. 1106 – Physician ownership-referral.** Changes to December 31, 2010, the date after which physician ownership of hospitals to which they self refer is prohibited and provides a limited exception to the growth restrictions for grandfathered physician owned hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).

**Sec. 1107 – Payment for Imaging Services.** Sets the assumed utilization rate at 75 percent for the practice expense portion of advanced diagnostic imaging services.

**Subtitle C – Medicaid**

**Sec. 1201. Federal funding for States.** 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. In the case of expansion states, reduces the state share of the costs of covering nonpregnant childless adults by 50 percent in 2014, 60 percent in 2015, 70 percent in 2016, 80 percent in 2017, 90 percent in 2018. In 2019 and thereafter, expansion states would bear the same state share of the costs of covering nonpregnant childless adults as non-expansion states (e.g., 7 percent in 2019, 10 percent thereafter).

**Sec. 1202 – Payments to primary care physicians.** Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100 percent of Medicare payment rates in 2013 and 2014 (the first year of the Senate bill's Medicaid coverage expansion to all individuals with incomes under 133 percent of poverty). Provides 100 percent federal funding for the incremental costs to States of meeting this requirement.

**Sec. 1203 – Disproportionate share hospital payments.** Lowers the reduction in federal Medicaid DSH payments from \$18.1 billion to \$14.1 billion and advances the reductions to begin in fiscal year 2014. Directs the Secretary to develop a methodology for reducing federal DSH allotments to all states in order to achieve the mandated reductions. Extends through FY 2013 the federal DSH allotment for a state that has a \$0 allotment after FY 2011.

**Sec. 1204 – Funding for the territories.** Increases federal funding in the Senate bill for Puerto Rico, Virgin Islands, Guam, American Samoa, and the Northern Marianas Islands by \$2 billion. Raises the caps on federal Medicaid funding for each of the territories. Allows each territory to elect to operate a Health Benefits Exchange.

**Sec. 1205 – Delay in Community First Choice Option.** Postpones from October 1, 2010 until October 1, 2011 the effective date of the option established for State Medicaid programs to cover attendant care services and supports for individuals who require an institutional level of care

**Sec. 1206 – Drug rebates for new formulations of existing drugs.** For purposes of applying the additional rebate, narrows the definition of a new formulation of a drug to a line extension of a single source or innovator multiple source drug that is an oral solid dosage form of the drug.

#### **Subtitle D – Reducing Fraud, Waste, and Abuse**

**Sec. 1301 – Community Mental Health Centers.** Establishes new requirements for community mental health centers that provide Medicare partial hospitalization services in order to prevent fraud and abuse.

**Sec. 1302 – Medicare prepayment medical review limitations.** Streamlines procedures to conduct Medicare prepayment reviews to facilitate additional reviews designed to reduce fraud and abuse.

**Sec. 1303 – CMS-IRS data match to identify fraudulent providers.** Allows the Secretary of Treasury to share IRS data with HHS employees to help screen and identify fraudulent providers or providers with tax debts, and to help recover such debts. Provides strict controls on the use of such information to protect taxpayer privacy.

**Sec. 1304 – Funding to fight fraud, waste and abuse.** Increases funding for the Health Care Fraud and Abuse Control Fund by \$250 million over the next decade. Indexes funds to fight Medicaid fraud based on the increase in the Consumer Price Index.

**Sec. 1305 – 90-day period of enhanced oversight for initial claims of DME suppliers.** Requires a 90-day period to withhold payment and conduct enhanced oversight in cases where the HHS Secretary identifies a significant risk of fraud among DME suppliers.

#### **Subtitle E – Revenues**

**Sec. 1401 – High-cost plan excise tax.** Reduces the revenue collected by the tax by 80 percent. This is achieved by:

Delaying the application of the tax until 2018, which gives the plans time to implement and realize the cost savings of reform;

Increasing the dollar thresholds to \$10,200 for single coverage and \$27,500 for family coverage (\$11,850 and \$30,950 for retirees and employees in high risk professions); excluding stand-alone dental and vision plans from the tax; and

Permitting an employer to reduce the cost of the coverage when applying the tax if the employer's age and gender demographics are not representative of the age and gender demographics of a national risk pool.

Under the modified provision, the dollar thresholds are indexed to inflation and the dollar thresholds are automatically increased in 2018 if CBO is wrong in its forecast of the premium inflation rate between now and 2018.

**Sec. 1402 – Medicare tax.** Modifies the tax to include net investment income in the taxable base. Currently, the Medicare tax does not apply to net investment income. The Medicare tax on net investment income does 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 is interest, dividends, royalties, rents, gross income from a 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 is reduced by properly allocable deductions to such income.

**Sec. 1403 – Delay of the annual limitation on contributions to a health FSA.** Delays the provision by two years until 2013.

**Sec. 1404 – Brand name pharmaceuticals.** Delays the industry fee on sales of brand name pharmaceuticals for use in government health programs by one year to 2011, and increases revenue raised by the fee by \$4.8 billion.

**Sec. 1405 – Excise tax on medical device manufacturers.** Delays the tax by two years to 2013 and converts the industry fee to an excise tax on the first sale for use of medical devices at a rate of 2.9 percent. Exempts from the tax Class I medical devices, eyeglasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use.

**Sec. 1406 – Health insurance providers.** Delays the industry fee by three years to 2014 and modifies the annual industry fee for revenue neutrality. In the case of tax-exempt insurance providers, provides that only 50 percent of their net premiums that relate to their tax-exempt status are taken into account in calculating the fee. Provides exemptions for voluntary employee benefit associations (VEBAs) and nonprofit providers more than 80 percent of whose revenues is received from Social Security Act programs that target low income, elderly, or disabled populations.

**Sec. 1407 – Delay of elimination of deduction for expenses allocable to Medicare part D subsidy.** Delays the provision by two years to 2013.

**Sec. 1408 – Elimination of unintended application of cellulosic biofuel producer credit.** Adds an additional revenue provision. In 2008, Congress enacted a \$1.01 per gallon tax credit for the production of biofuel from cellulosic feedstocks in order to encourage the development of new production capacity for biofuels that are not derived from food source materials. Congress is aware that some taxpayers are seeking to claim the cellulosic biofuel tax credit for unprocessed fuels, such as black liquor. The provision would limit eligibility for the tax credit to processed fuels (i.e., fuels that could be used in a car engine or in a home heating application).

**Sec. 1409 – Codification of economic substance doctrine and penalties.** Adds an additional revenue provision. The economic substance doctrine is a judicial doctrine that has been used by the courts to deny tax benefits when the transaction generating these tax benefits lacks economic substance. The courts have not applied the economic substance doctrine uniformly. The provision would clarify the manner in which the economic substance doctrine should be applied by the courts and would impose a penalty on understatements attributable to a transaction lacking economic substance.

**Sec. 1410 – Time for payment of corporate estimated taxes.** Provides for a one-time adjustment to corporate estimated taxes for payments made during calendar year 2014.

**Sec. 1411 – No impact on Social Security trust funds.** Provides that Title II of the Social Security Act (the old age, survivor, and disability benefits program (OASDI) is not amended or modified by the bill.

**HealthCareAlert** is published by Grant Thornton LLP. It is not intended to answer specific questions or suggest suitability of action in a particular case. For additional information on the issues discussed in the newsletter, consult your Grant Thornton client-service partner.

---

Grant Thornton LLP is the U.S. member firm of Grant Thornton International, one of the six global accounting, tax and business advisory organizations. Through member firms in 110 countries, including 50 offices in the United States, the partners and employees of Grant Thornton member firms provide personalized attention and the highest quality service to public and private clients around the globe. Visit Grant Thornton LLP at [www.GrantThornton.com](http://www.GrantThornton.com).