HIGHLIGHTS FROM THE 2010 HEALTHCARE REFORM ACT

COWAN, GUNTESKI & CO., P.A.
Certified Public Accountants and Consultants

April 2010

On March 23, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). This legislation, along with the Health Care and Education Affordability Act of 2010 (HCEA), signed on March 30, will change healthcare in the United States. Every employer, medical practice, and citizen will be impacted by this legislation.

While many of the changes mandated by these bills will not be implemented for a number of years, others will take effect immediately.

These landmark bills will impact many key health reform areas. Even so, neither bill addresses the issues related to the Sustainable Growth Rate formula. Physicians continue to be subject to a last-minute guessing game on whether Medicare reimbursement will drop sharply, or if Congress will step in at the last minute to stop the cuts from being implemented. It is expected that Congress will address this problem when it returns from recess in April.

The two bills (PPACA and HCEA) exceed 3,000 pages. This article highlights some of the more important areas that will impact employers, medical practices, and patients.

EMPLOYERS

There has been much discussion – positive and negative – about the potential financial impact of this legislation on employers, especially small businesses. It is important to keep in mind that the law does not require employers to provide health insurance coverage. It does require automatic enrollment in plans sponsored by large and mid-sized employers. Employers that do not provide minimum essential coverage will be liable for an additional tax.

Large employer penalty – Employers with an average of at least 50 full-time equivalent employees (30-hours or more per week) during the preceding calendar year will have to pay a penalty if they do not provide adequate minimum essential healthcare coverage. Effective in 2014, a monthly penalty in the amount of 1/12 of $2,000 per full-time employee will be assessed. The law excludes the first 30 employees from the calculation. Employers with fewer than 50 employees are exempt from this requirement.

In addition, employers with 50 or more full-time employees that offer coverage but have at least one full-time employee receiving a premium tax credit or cost-sharing reduction for health insurance purchased through a state Exchange will pay a monthly excise tax in the amount of 1/12 of $3,000 for each full-time employee that receives either subsidy. This penalty is capped at the amount that the employer would be assessed for failure to provide coverage, as specified above.

Small business tax credits – For tax years 2010 through 2013 employers with no more than 25 full-time employees and average wages of less than $50,000 per employee could qualify for a tax credit of up to 35% of employer contribution premiums. In general, the

employers' contribution would equal 50% of the premium cost. Employers with less than 10 employees earning an average of $25,000 per year will be entitled to the full credit. The credit phases out as company size and/or average employee wages increase.

In 2014, if a qualified small business purchases coverage through a state-based Exchange a 50% credit will be available for two years.

"Free choice" voucher requirement – Employers that provide the minimum essential coverage to employees will be required to give certain employees a "free choice" voucher if their income does not exceed 400% of the federal poverty level. To qualify the employee's contribution to an employer-provided plan has to exceed 8% of household income (but not more than 9.8% of income) and the employee has to enroll in a Heath Care Exchange plan.

Excise tax on "Cadillac" or high-cost employer-sponsored health coverage – Beginning in 2018, the law would place a 40% nondeductible excise tax on insurance companies and plan administrators for any health coverage plan if the annual premium exceeds $10,200 for individual coverage and $27,500 for family coverage. Standalone dental and vision plans are excluded from the amount subject to tax. A higher premium level of $11,850 for individual coverage and $30,950 for family coverage is imposed for employees in high-risk professions and retired employees age 55 and older who are not eligible for Medicare.

Reporting requirements – Beginning January 1, 2011, employers must disclose the value of the benefit provided by them for each employee's health insurance coverage on the employee's W-2. These benefits will continue to be non-taxable to the employee under most circumstances. Businesses must also file an information tax return for payments totaling more than $600 per calendar year to a single provider of property and services, including corporations (unless tax-exempted).

No discrimination based on salary – New group health plans are prohibited from establishing any eligibility rules for health insurance coverage that have the effect of discriminating in favor of higher-wage employees.

Discriminatory practices – Discriminatory practices are not allowed against small businesses and the self-employed such as denial of coverage, because of health status, age, or pre-existing conditions.

Fees on health-related industries – Annual, nondeductible fees are imposed on various health-related industries. For example, pharmaceutical manufacturers and importers will have to pay an annual flat fee beginning in 2011, allocated across the industry based on market share. Starting in 2013, manufacturers or importers of medical devices will have to pay an additional 2.3% tax on the sale price of these devices. IRS-specified medical devices sold at retail establishments for personal use such as eyeglasses, contact lens and hearing aids are exempt from the excise tax. Health insurance providers will face an annual flat fee on the health insurance sector, effective January 2014.

MEDICAL PRACTICES

A majority of both pieces of legislation will have an impact on medical practices. Many of these changes are intended to move the healthcare system to look more at quality of care and preventive services. Every medical practice will need to make changes to how they operate to be in compliance. Medical practices that have provided care to uninsured patients may now be able to be paid once these individuals have the ability to obtain coverage.

Medicare benefits – Neither law includes any cuts to traditional Medicare benefits.

Medicare annual wellness – Beginning in 2011, Medicare will cover annual wellness visits, including a health risk assessment, health advice and referrals to education and preventive counseling. These services will not be subject to a copayment or deductible.

More affordable Medicare preventive services – Beginning in 2011, copayments and deductibles will not apply to certain preventive services recommended by the Preventive Services Task Force for Medicare patients.

Medicaid preventive services – Beginning in 2010, Medicaid will be required to cover tobacco cessation services for pregnant women. In 2011, Medicaid will begin to cover preventive services at 100% coverage.

Incentive payments for primary care physicians – Physicians specializing in family medicine, internal medicine, geriatrics, and pediatrics will be eligible for up to a 10% bonus payment for evaluation and management services from 2011 to 2016.

Incentive payments for mental health services – For 2010, Medicare will increase payment for psychotherapy services by 5%.

Geographic payment differentials – The national average GPCI has been re-established for 2010. Medicare reduces the GPCI adjustment for physician practice expenses in rural and low cost areas.

Incentive payments extended – Incentive payments of 1% in 2011 and 0.5% from 2012 to 2014 will continue to

be available for voluntary participation in the Medicare Physician Quality Reporting Initiative (PQRI). An additional 0.5% incentive payment will be made to physicians who participate in a qualified Maintenance of Certification Program. Beginning in 2015, physician payments from Medicare will be reduced by 1.5% for physicians who do not successfully participate in the PQRI program. In subsequent years, the penalty will be 2%. There will also be public reporting of the participation of physicians in the PQRI program.

PQRI Alternative – The law allows for physicians to participate in the American Board of Medical Specialties Maintenance of Certification as an option for fulfilling CMS requirements for PQRI starting in 2011.

Medicaid payments – Medicaid payments to physicians specializing in family medicine, general internal medicine, and pediatrics for evaluation and management services as well as immunizations will increase to a level at least equal to Medicare rates in 2013 and 2014. The bill provides for 100% federal funding for the incremental costs incurred by states in meeting this requirement.

Administrative simplification – Beginning in 2010, rules will be developed and implemented between 2013 and 2016 to standardize and streamline health insurance claim processing requirements. These changes are intended to make it easier to track claims and should reduce practice overhead costs.

Claim submission time limit – The time limit for submitting claims to Medicare has been reduced to 12 months, effective January 1, 2010. In the past, physicians had between 15 and 26 months to submit claims.

Increases in the number of Primary Care Practioners – The laws provide for funding for increased training for primary care practitioners, including doctors, nurses, nurse practitioners, and physician assistants, effective beginning in fiscal year 2011.

Medical liability – Beginning in 2011, the Secretary of the Department of Health and Human Services (HHS) is authorized to award five-year demonstration grants to states to develop, implement, and evaluate alternative medical liability reform initiatives, such as health courts and early offer programs. Medical liability protection under the Federal Tort Claims Act will be extended to officers, governing board members, employees, and contractors of free clinics.

Enrollment screening – New screening processes will be in place when a physician enrolls or revalidates as a Medicare provider. The process will be at the discretion of the HHS and the Office of the Inspector General (OIG). If the agencies feel that providers pose a risk, background checks and fingerprinting can be required, as well as unannounced site visits.

Prohibition on physician referrals for hospitals – Physicians are prohibited from referring to physician-owned hospitals unless they are grandfathered in before August 1, 2010.

Fraud and abuse – The government will now have the authority to suspend payments to providers pending a fraud investigation. Fraud and abuse agencies will receive increased funding.

RAC Audits – RAC Audits were expanded to include identification of underpayments and overpayments for Medicaid services and Medicare Advantage plans.

Physician ownership or investment interests – Manufacturers of medical devices and equipment must report transfers of ownership or other financial interests to physicians, practices, and teaching hospitals beginning in 2013. These transfers include consulting fees, honoraria, gifts, speaking fees, and charitable contributions, among other items.

Overpayments – Physicians will be required to report and return any overpayments that are discovered to their Medicare carrier or MAC within 60 days.

Referral documentation – Physicians will need to provide written documentation of referrals and orders for all services and equipment, including home health services. Failure to have this documentation available upon request may result in a one-year suspension from Medicare.

Self-referral disclosure policy – HHS and OIG will create a policy for providers to disclose any actual or potential violations of the physician self-referral law. This will be issued within six months of enactment of the law.

Value based reimbursement – The law establishes a value based payment system, which will be phased in starting in 2015. The system adjusts Medicare fee schedules to be based on quality of care. The criteria will be established by the Secretary of HHS.

Medicare Advantage plans – The law cut $132 billion in subsidies to the private companies that offer Medicare Advantage plans over a 10-year period. The cut will be achieved by restructuring payments to Medicare Advantage Plans. Areas with low Medicare fee-for-service payments will be compensated with higher payments. Beginning in 2012, bonus payments will be made for Medicare Advantage plans that achieve certain quality standards. This may result in these plans

dropping some of the extra benefits they currently offer as they feel the effect of the budget cuts.

Independent Payment Advisory Board – A 15-member independent panel will be formed to act when Medicare costs are projected to be unsustainable. They cannot ration patient care, raise taxes, or change premiums, eligibility or benefits.

CONSUMERS

A great deal of speculation has permeated the media about how patients will be impacted by healthcare reform. Many patients who currently do not have coverage will be able to obtain medical insurance through one of a number of channels.

Existing coverage **–** Individuals who currently have coverage and wish to retain it can do so under a grandfather provision in the legislation. The coverage will be deemed to meet the individual's responsibility to have insurance. Employers currently offering coverage are also grandfathered.

Covering the uninsured – The Act expands Medicaid to cover individuals earning less than 133% of the federal poverty level, or $14,404 for individuals or $29,327 for a family of four, according to current guidelines.

Health Care Exchanges (also called Small Business Health Options Programs – SBHOP) – The law mandates that states create Health Care Exchanges. These Exchanges can be administered by a government agency or nonprofit organization. The federal government will fund these Exchanges with start-up money with the goal that they be operational by 2014. Initially, Exchanges will be open only to those who work for firms with 100 or fewer employees and to individuals looking to buy insurance for themselves. These individuals could be self-employed, unemployed, or retired but not yet eligible for Medicare. The Exchanges are meant to function as a cooperative that allows interested individuals to band together for purchase coverage. Each Exchange will offer four levels of plans of declining expense – platinum, gold, silver, and bronze – and work to create standardized levels of coverage. This will make comparisons across plans easier for consumers.

Penalty for remaining uninsured – By 2014, most Americans must have health insurance or pay a penalty. The penalty would start at $95 for an individual or up to 1% of income, whichever is greater, and increase to $695 or 2.5% of income by 2016. The limit on a family's penalty is 300% of the applicable dollar amount for the year ($2,085 in 2016). For individuals under age 18 or in college the applicable flat dollar penalty would be one-half of the stated penalty amount. Some people may be exempt from the insurance requirement because of financial hardship or religious beliefs. Individuals who cannot afford coverage because the contribution for employer-sponsored coverage or the cost of the "bronze" plan offered by the Health Care Exchange exceeds 8% of household income are exempt.

Low income tax credits for participating in Health Care Exchanges – Individuals and families making between 100% and 400% of the federal poverty level wanting to purchase their own health insurance from the Exchanges will be eligible for premium credits.

Pre-existing conditions – The law bars health insurance companies from denying coverage to individuals with pre-existing conditions. This takes effect for children six months after passage of the law and for adults starting in 2014.

Lifetime maximum coverage – Within six months after enactment, health insurance companies are banned from placing lifetime caps on coverage.

No rescissions – Bans health insurance carriers from dropping people from coverage when they get sick. Effective six months after enactment.

Medicare Part D coverage hole **–** The law provides a $250 rebate to Medicare beneficiaries who hit the "donut hole" in 2010. The donut hole is the gap in coverage between the basic Medicare Part D benefit and the catastrophic coverage benefit. Beginning in 2011, there will be a 50% discount on brand-name drugs in the donut hole. The donut hole will be completely closed by 2020.

More affordable Medicare preventive services – Beginning in 2011, copayments and deductibles will not apply to certain preventive services recommended by the Preventive Services Task Force for Medicare patients.

Extension of coverage to young adults – Requires health plans to allow dependent (for tax purposes) children up to age 26 to remain on their parents' employer-provided accident or health plan, at the parents' discretion. This takes effect six months after the passage of the bill.

Disease specific programs – Funding is provided for disease specific programs such as those dealing with obesity and diabetes. The funding is specifically for those illnesses which create a huge financial drain on the healthcare system.

Medicare tax – Starting in 2013, families making more than $250,000 per year (individuals making more than $200,000) will pay more in Medicare payroll taxes. The rate will increase from 1.45% to 2.35%. The employee

portion of Medicare payroll tax will also be expanded to include unearned income of 3.8% on investment income for families with AGI above $250,000 per year ($200,000 for individuals). The new tax will apply only to income above the $250,000/$200,000 threshold. Investment income includes interest, dividends, royalties and rents. Self employed individuals, as well as estates and trusts, will be liable for the additional tax. However, the 3.8% surtax does not apply to qualified retirement plans and individual retirement account distributions.

Flexible Spending Accounts – The amount of contributions to health flexible spending accounts (FSA) will be limited to $2,500 per year effective for tax years beginning after December 31, 2012. This amount will be inflation indexed after 2013. There will also be changes that will no longer permit the reimbursement of over-the-counter medications that are not physician prescribed through health savings accounts (HSA), health reimbursement arrangements (HSA) or Archer medical savings accounts (MSA) beginning in 2011. The tax on nonqualified distributions from HSAs and MSAs increases to 20%.

Medical expense deductions – The adjusted gross income (AGI) threshold for claiming the itemized deduction for medical expenses would increase from 7.5% to 10% for individuals under the age of 65. The 7.5% threshold would continue through 2016 for individuals 65 and older.

Help for early retirees – The bill creates a temporary re-insurance program to help offset the costs of expensive health claims for employers that provide health benefits for retirees between the ages of 55 and 64 until the Health Care Exchanges are available. Payments made under the reinsurance program would be excluded from gross income.

Uninsured with pre-existing conditions – Immediate access to insurance is provided for people who are uninsured because of a pre-existing condition through a temporary high-risk pool until the Exchanges are functioning. This pool will be effective 90 days after enactment of the bill.

Catastrophic coverage – People in their 20s will have the option of buying a catastrophic plan that will have lower premiums. The coverage will kick in after the individual has $6,000 in out-of-pocket expenses.

Preventive services – Preventive services, such as mammograms and immunizations, must be covered by insurers, with no co-payment or deductible required. Effective six months after enactment or beginning on January 1, 2011 for Medicare.

Although the information outlined above seems exhaustive, it does not include all the changes that will affect the healthcare system. More information on the heath reform legislation can be found at http://www.whitehouse.gov/health-care-meeting/proposal. The full text of both laws will be published in the Federal Register in the next few weeks.

Since these initiatives have varying implementation dates, businesses should carefully evaluate which aspects of the legislation affect them and create a budget to determine the financial impact on their organization. Businesses should work with their insurance brokers, healthcare attorneys and CPAs to ensure compliance. The changes may require modification of employee handbooks, employment contracts and corporate documents.

There may be efforts in the coming months and years prior to 2014 to roll back some of the changes found in this legislation. Businesses, medical practices and individuals should continue to monitor the news carefully to understand the full impact of the healthcare reform.

The Cowan, Gunteski & Co., P.A. Healthcare Team is available to answer questions on how this legislation will impact your practice. Please feel free to contact Deborah Mathis, CPA, CHBC or Michael Lewis, MBA, FACMPE at 732-349-6880.

Published Nationwide by CPAmerica, Inc.

MICHAEL LEWIS, MBA, FACMPE
DIRECTOR – HEALTHCARE SERVICES GROUP