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May 21, 2009

To: State Unit Directors
From: Martha Roherty, Peggie Rice, and Cathy Rudd
RE: U.S. Senate Finance Committee Report on Health Care Financing Proposals

On May 18, the Senate Finance Committee issued its third report on health care reform policy options. The report is titled, "Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options." As with the two earlier reports, this report in large part does not provide specific solutions but does give the committee's "proposed option." Not all options in the document have the support of Chairman Baucus or Ranking Member Grassley. Three specific areas of potential funding sources are explored:

1. Reductions in current health care spending;
2. Reevaluating current health tax subsidies; and
3. Changes to non-health tax provisions.

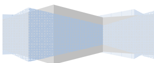
Below you will find a brief summary of the report. For access to the complete report, please see:

http://finance.senate.gov/sitepages/leg/LEG%202009/051809%20Health%20Care%20Description%20of%20Policy%20Options.pdf

SECTION I: Health Systems Savings

In addition to delivery system improvements addressed in earlier roundtables, policies to address spending growth in Medicare and Medicaid have been examined by MedPAC, CBO, and the Administration. Options for potential areas of savings in Medicare and Medicaid are described below:

Ensuring Appropriate Payment



Improving Payment Accuracy through Adjusting Annual Market Based Updates -- Most fee-for-service Medicare providers receive predetermined payment amounts established under different, unique prospective payment systems. The base payment amounts in the different Medicare payment systems

are increased each year and those increased are linked to specific market basket (MB) indices, which measure inflation. The Medicare Payment Advisory Commission (MedPAC) makes payment update recommendations each year and its 2009 Report to Congress recommended that a number of providers receive reduced or eliminated Medicare market basket updates in FY2010.

Proposed Options: Options to adjust annual market basket updates include reducing or eliminating updates in 2010 for a provider payment area recommended by MedPAC or establishing differential payment updates for low and high-margin areas.

Updating Payment Rates for Home Health Services – In its 2009 Report to Congress, MedPAC reported that most HHAs were paid above costs. MedPAC recommended that Congress eliminate the market based increase for home health services in 2010 and recommended the Secretary rebase rates for home health care services in 2011 to more closely reflect the cost of visits and other services delivered in the average HH episode.

Proposed Options: One option may include implementing MedPAC's recommendations regarding market basket adjustments in 2010. Another option may be to direct the Secretary to "re-base" home health payments to better reflect the current number and mix of HH services, their intensity and the relative margins related to specific conditions and service areas. Other options include establishing a provider-specific cap on the number of allowable outlier episodes that HHAs can be reimbursed for in a year.

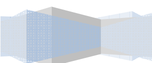
Updating Payment Rates for Inpatient Services – Both Medicare and Medicaid provide additional payments to hospitals that train medical residents or serve a high proportion of low-income patients.

Proposed Options: One option would be adjusting current Graduate Medical Education (DME) and Medicare Disproportionate Share Hospital (DSH) payment levels over time as the need for these resources decrease as more individuals become insured as a result of health care reform. Another option would be to consolidate Medicare and Medicaid payments to hospitals as a way to streamline and better account for and coordinate federal funding within the DSH and GME payment areas.

Adjusting Reimbursement for High-Growth, Over-Valued Physician Services – In 2005, MedPAC recommended reducing certain fees for imaging and other services.

Proposed Options: The committee will explore making payments to Part B providers more rational through reforms that appropriately value services, such as the MedPAC recommendation to increase the utilization rate for calculating the payment for advanced diagnostic imaging services. Another option is to establish an expert panel to assist CMS in evaluating and adjusting payment for potentially misvalued physician services.

More Appropriate Payment for Durable Medical Equipment (DME) –



Proposed Option: The Office of Inspector General (OIG) at HHS has identified potentially overvalued DME items and services; some contend reimbursement for certain DME items and services are under-

reimbursed. The committee will explore options to improve payment accuracy for DME items and services.

Increase the Medicaid Brand-Name and Generic Drug Rebate Amounts –

Proposed Options: The Committee could consider increasing Medicaid's flat rebate from 15.1 percent to as much as 23.1 percent. Under this option, the Medicaid best price provision would remain unchanged. Another option would be an increase in the basic Medicaid rebate for non-innovator, multisource drugs from 11 percent to 13 percent of average manufacturer price (AMP). The committee paper does not address whether amounts retained by the state would change.

Extend to and Collect Rebates on Behalf of Managed Care Organizations (MCOs) –

Proposed option: The Committee is considering one option to require prescription drug manufacturers to pay a rebate on drugs purchased for beneficiaries in the risk-based managed care component of Medicaid that is similar to the rebate required in the FFS Component of the program. Manufacturers could be required to pay the Medicaid FFS rebate directly to states. MCOs could still negotiate additional rebates above the amount defined in law.

Application of Rebates to New Formulations of Existing Drugs –

Proposed Option: This option would consider the line-extensions of existing drugs as if they were the original product for purposes of calculating the additional rebate. Under this option, when a new, extended release version of a drug is introduced the additional rebate obligation for the new drug would be either the AMP percentage that is owed under current law or the AMP percentage owed for the original drug, whichever is greater. This would correct the situation today that permits drug makers to avoid incurring additional rebate obligations by making slight alterations to existing products.

Capturing Productivity Gains

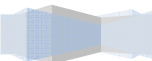
Generally, Medicare's annual updates are linked to projected inflation. According to CBO, market basket updates overstate actual costs to providers because they do not assume increases in provider productivity that could reduce the actual cost of providing services.

Proposed Options: The committee could consider requiring annual market basket adjustments for certain providers to be adjusted by some or all of the expected productivity gains as a way to improve the accuracy of Medicare payments.

Reducing Geographic Variation in Spending

Researchers have found that health care spending varies widely across the United States and that high cost areas may not always provide better quality of care.

Proposed Options: To reduce inappropriate spending variations across and within geographic areas, the



Committee could broadly review all Medicare Part A and B spending and propose reductions in areas where per beneficiary spending is above a certain threshold compared with the national average. Or it could require spending reductions only for individual providers who are above a certain threshold in spending compared to their peers in their local area. Policy options would have to be weighed against delivery system reform options, which also intend to reduce geographic variations in spending.

Modifying Beneficiary Contributions

Making Beneficiary Contributions More Predictable -- Medicare cost sharing can be significant, complex and vary by the type of service. Current law lacks fundamental protections for the total amount of cost sharing that Medicare beneficiaries could face in any given year. Therefore, many beneficiaries have supplemental coverage either purchased through Medigap or through retiree benefits offered by former employers. While supplemental coverage helps make Medicare contributions more predictable for beneficiaries, it also prevents Medicare from using cost sharing as a policy tool. Incentives to encourage or discourage cost- conscious decision-making may be blunted by the complexity of the structure of beneficiary obligations. Studies have also found that beneficiaries with supplemental coverage use more services than those without it. MedPAC says spending tends to be higher by those with supplemental coverage than those without it, especially for elective procedures, medical specialists, and imaging.

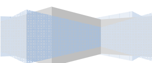
Proposed Options: One option is simplifying Medicare beneficiary cost-sharing obligations and making them more consistent with benefits that are available in the private sector. This could be accomplished by making changes to Medicare's cost-sharing requirements (e.g., out of pocket maximums for Parts A and B) while placing restrictions on Medigap policies (e.g., require some cost sharing but with catastrophic protection). By making both changes, beneficiaries with supplemental policies wouldn't be insulated from the effects of Medicare cost-sharing modifications.

Means Testing Part D Premiums –

Proposed Options: One option would be requiring beneficiaries whose incomes exceed certain thresholds to pay higher premiums for Part D drug coverage. Higher premiums could apply only to basic coverage. The income thresholds could be set at the same levels and adjusted in the same manner as under Part B.

Another option that could be considered on its own or in conjunction with other changes is to allow more beneficiaries with low incomes to be eligible for the low-income subsidy (LIS) program by raising the asset limits. Additional resources could be allocated for outreach and education of low-income beneficiaries who qualify for LIS but do not enroll in Part D.

The committee could also consider options to reduce the size and effect of the "donut hole." One option is to modify the out-of-pocket threshold so that it grows more slowly so that over a number of years the initial coverage limit catches up with the out-of-pocket threshold and eliminates the donut hole completely. Another option could be to require the prescription drug plans to offer some level of



coverage for the donut hole in their enhanced benefit packages.

SECTION II: Options to Modify the Exclusion for Employer-Provided Health Care -- Employees are generally not taxed on the value of employer-provided health coverage.

Proposed Options: A number of options could be considered that would limit the value of employer-provided health coverage that is excludible from gross income. The limit could be based on the value of the plan or the income of the insured, or the limit could be a combination of both. Or it could be tied to a percentage of the value of the employer-provided health coverage. Another option would be to apply the limit only to taxpayers whose incomes exceed a threshold income level. A third option would be to limit the exclusion based on both the value of employer-provided health insurance and the income of the taxpayer.

SECTION III: Other Health Care Related Revenue Raisers

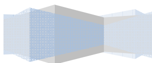
Modify or Repeal the Itemized Deduction for Medical Expenses – Itemized deductions are allowed for unreimbursed medical expenses that exceed 7.5% of one's adjusted gross income.

Proposed Options: The Committee could consider raising the 7.5% AGI threshold for the itemized deduction for medical expenses or could eliminate the deduction.

Repeal or Modify the Special Deduction and Special Unearned Premium Rule for Blue Cross and Blue Shield and Other Qualifying Organizations – A property and casualty insurance company is subject to tax on its taxable income, generally defined as its gross income less allowable deductions. Present law provides that an organization described in sections 501(c)(3) and (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance. However, a special deduction and a special exception apply to taxable BCBS organizations, and there are other qualifying organizations. Under the special rules for such BCBS and other qualifying organizations, a special deduction applies with respect to health business of such organizations, equal to 25 percent of the claims and expenses incurred during the taxable year less the adjusted surplus at the beginning of the taxable year. In addition, an exception is provided for such organizations from the application of the 20-percent reduction in the deduction for increases in unearned premiums that applies generally to property and casualty companies.

Proposed Options: The Committee could consider repealing the special deduction for 25 percent of claims and expenses, and the exception from the reduction of deductible unearned premiums, in the case of Blue Cross and Blue Shield and other qualifying orgs. Alternatively, the proposal option could reduce the percentage of the special deduction and the exception from the reduction of deductible unearned premiums.

Modify Health Savings Accounts – Like IRAs, an HSA is a tax-exempt account held by a trustee or custodian for the benefit of the individual who must be covered under a high deductible health plan. Contributions made by individuals are deductible for income tax purposes. A high deductible health plan has an annual deductible of at least $1,150 for self-only coverage or $2,300 for family. That limits



the sum of the annual deductible and other payments the individual must make to $5,800 for individual coverage or $11,600 for family coverage. For 2009, the maximum annual contribution for individual coverage is $3,000 and for a family is $5,950. For those 55 or older, the contribution limit is $1,000 greater.

Proposed Options: HSA contributions could be limited to the lesser of the individual's deductible under the high deductible health plan or the dollar amount of the maximum allowable aggregate HSA contributions.

<u>Modify or Repeal the Exclusion for Employer-Provided Reimbursement of Medical Expenses Under Flexible Spending Arrangements (FSA) and Health Reimbursement Arrangements (HRA)</u> – Employers may agree to reimburse medical expenses of employees not covered by a health insurance plan through FSAs or HRAs.

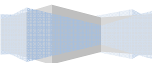
Proposed Options: One option would be to place a limit on the amount of salary reduction contributions to a health FSA that would be excludible from gross income. Or the exclusion for salary reduction contributions to a health FSA could be eliminated. Similar changes could be made to the exclusion for reimbursements for medical expenses under an HRA. If a limit were placed on the current exclusion for employer-provided health coverage, contributions to an FSA or HRA could be counted against the limit.

<u>Limit the Qualified Medical Expense Definition</u> – Any amounts paid for prescription medicines are deductible as a medical expense under the rules relating to itemized medical expenses. Over-the-counter medicine is not deductible as medical expense.

Proposed Option: The definition of medical expense for purposes of employer plans and health savings accounts could be conformed to the definition for purposes of the itemized deduction for medical expenses. Thus, under the proposal, the cost of nonprescription medicines would not be reimbursed through a flexible spending arrangement.

<u>Modify FICA Tax Exception for Students</u> – Under FICA, a tax is imposed on wages paid with respect to employment for (1) old age, survivor and disability insurance ("OASDI") for Social Security monthly benefits after retirement, disability, or death; and (2) Medicare hospital insurance ("HI"). Some forms of compensation are excepted from the definition of wages, such as employer-provided health benefits, as are certain types of services or services performed by certain employees, which are excepted from the definition of employment. Compensation or services excepted are not subject to FICA tax.

Such an exception applies to a student in the employ of a school, college, or university. The scope of the student exception has been the subject of uncertainty in recent years with the courts and the IRS coming down differently on the issue. Contrary to the government's (IRS) position that medical residents do not qualify for this exception, several courts have found that the student exception may apply depending on the nature of the program and the status of the hospital or other medical facility. The regulations say an employee must perform services for a school at which he or she is enrolled and



regularly attending classes in pursuit of a certificate or degree. The employee's services must be incident to and for the purpose of pursuing a course of study at the school, college, or university. The regulations provide that a full time employee's services are not incident to and for this purpose.

Proposed Option: This policy option would codify the IRS regulations that clarify the scope of the present-law student exception. In addition, the proposal would amend the student exception so that it does not apply to those whose earnings exceed an annual dollar limit. Under the policy option, the student exception applies for a year only if the individual's earnings from school are less than the amount needed to receive a quarter of FICA coverage for the year ($1,090 for 2009). Thus, if an individual's earnings exceed the limit, his or her earnings are subject to FICA regardless of meeting other requirements for the exception.

Extend Medicare Payroll Tax to all State and Local Government Employees – State and local government workers are not covered by Medicare or subject to the HI tax if they were hired before March 31, 1986, and they are not covered by a voluntary agreement and are covered by a retirement plan. Certain classes of State and local employees are exempt from the hospital insurance tax, such as certain election workers.

Proposed Option: The option would extend Medicare coverage on a mandatory basis to all employees of State and local governments, without regard to their dates of hire or participation in a retirement system. Employees and their employers would become liable for the HI tax and employees would earn credit toward Medicare eligibility.

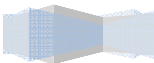
Modify the Requirements for Tax-Exempt Hospitals – Since 1969, the IRS has applied a "community benefit" standard for determining whether a hospital is charitable. Community benefits can include, for example: maintaining an emergency room open to all persons regardless of ability to pay; having an independent board of trustees with representatives of the community; and operating with an open medical staff policy. Some argue the community benefit standard, a facts and circumstances test, is imprecise and not sufficiently stringent.

Policy Options: One option is to codify organizational and operational requirements for determining whether a hospital is a charitable section 501(c)(3) tax-exempt organization, such as regularly conducting a community needs analysis, providing a minimum annual level of charitable patient care, not refusing services based on a patient's ability to pay, and following certain procedures before instituting collection actions against patients.

SECTION IV: Lifestyle Related Revenue Raisers

Impose a Uniform Alcohol Excise Tax – Per ounce, distilled spirits are taxed at roughly 21 cents per ounce of alcohol, still wines at 8 cents per ounce, and beer at 10 cents per ounce.

Proposed Option: One option contemplates imposing a uniform tax based on the alcohol content contained in the product. The excise tax under the proposal is imposed at a rate of $16 per proof gallon on all alcoholic beverages.



<u>Enact a Sugar-Sweetened Beverage Excise Tax</u> – Present law does not include such a tax.

Proposed Option: The proposal would impose a Federal excise tax per 12 ounces of sugar- (or high-fructose corn syrup or other similar sweetener-) sweetened beverage including carbonated and uncarbonated beverages such as nondiet soft drinks, fruit and vegetable drinks, energy and sports drinks, iced teas and coffees and flavored milk and dairy drinks. Beverages sweetened with non-caloric sweeteners would not be taxed.

SECTION V: Administration's Revenue Raising Proposals

The President has outlined a number of possible revenue raising provisions as part of the Administration's fiscal year 2010 budget proposals. In Committee discussions on health care reform, the focus has been on health care-related program savings and revenue raising proposals. However, the Chairman desires to provide, for the information of Members and potential discussion, a list of the President's Budget proposals. Below are the broad categories. The complete lists (without details) are in the report.

<u>Revenues Dedicated to the Health Reform Reserve Fund</u>

1. Limit the Tax Rate at which Itemized Deductions Reduce Tax Liability to 28 Percent
2. Reduce the Tax Gap and Make Reforms
3. Make Reforms to Close Tax Loopholes
4. Modify Alternative Fuel Mixture Credit

<u>Other Revenue Raising Proposals</u>

1. Other Revenue Changes and Loophole Closers
2. Upper-Income Tax Provisions Dedicated to Deficit Reduction
3. User Fees
4. Other Initiatives

NASUA will continue to monitor all Senate and House Health Reform activities. Please feel free to contact Martha, Peggie or Cathy if you have any questions.