



**Health Reform Reconciliation Bill (H.R. 4872) Amending the
Senate-Passed Patient Protection and Affordable Care Act**
Avalere Health Initial Summary and Analysis

On March 18, 2010, Democrats in the House of Representatives released legislative language that would amend the Senate-passed Patient Protection and Affordable Care Act. The legislation mirrors the provisions set forth by the President's proposal on February 22, 2010, but does not include every proposal in that document because of strict reconciliation rules in the Senate. The House leadership has scheduled a floor vote on the bill for Sunday, March 21. At that time, each member will cast a single vote to simultaneously approve the reconciliation package and deem the Senate's Patient Protection and Affordable Care Act passed. If the House passes the bill, the original Senate bill will go to the President for signature, and the reconciliation package will move to the Senate for approval. The reconciliation package only requires 51 votes to pass in the Senate, but could face procedural hurdles.

Consistent with the President's proposal, the reconciliation package would:

- Increase premium and cost-sharing subsidies for individuals earning less than 400 percent of the federal poverty level (FPL);
- Extend some insurance reforms (e.g., prohibitions on annual and lifetime limits) to "grandfathered" plans;
- Alter the individual mandate penalties to make them more progressive;
- Close the Medicare Part D "donut hole" or coverage gap by 2020;
- Set Medicare Advantage benchmarks based on fee-for-service Medicare costs plus bonus payments for quality and enrollee satisfaction;
- Reduce the impact of the Cadillac tax and increase Medicare payroll taxes on individuals earning more than \$200,000 per year;
- Add several new proposals to fight fraud and abuse;
- Increase Federal Medicaid payments to states; and
- Revise fees on health care industries.

Unlike the President's proposal, the bill does not include a health insurance rate review commission that would monitor annual premium increases. It also:

- Eliminates the Senate bill provision that would have expanded 340B pricing to drugs dispensed by qualifying hospitals in the inpatient setting;
- Lowers reductions to Medicare and Medicaid Disproportionate Share Hospital (DSH) payments and increases hospital market basket cuts; and
- Increases payment reduction for Medicare imaging services by including higher utilization assumptions.

In combination, the reconciliation package and the Patient Protection and Affordable Care Act are estimated to cost \$940 billion over ten years. The bills are expected to reduce the federal deficit by \$138 billion over 10 years and \$1.2 trillion dollars in the second decade after passage. The bills are expected to reduce the uninsured population so that by 2016 92% of the non-elderly US population will have insurance coverage and 95% of the population, excluding undocumented immigrants.

For a full copy of the reconciliation bill, please go to:
http://docs.house.gov/rules/hr4872/111_hr4872_amndsub.pdf

A Closer Look: The Part D Coverage Gap Proposal

The reconciliation package modifies the Senate bill by closing the Part D donut hole beginning in 2013 and fully closing the gap by 2020. This was not included in the Senate-passed bill. The proposal would still require drug manufacturers to provide 50 percent discounts for all brand-name Part D drugs dispensed in the donut hole, but the start date is delayed until January 1, 2011 (previously July 1, 2010). It then requires PDPs to reduce the coinsurance that beneficiaries who are eligible for the discount program will pay on drugs in the coverage gap. This requirement will be phased in, with separate rules for generics and brands. For brands, plans will cover 2.5 percent of the negotiated price in 2013, rising to 25% in 2020. For generics, plans will have to reduce coinsurance to 93% in 2011, falling gradually to 25% in 2020. The discount program will remain in effect, so the net amount that beneficiaries pay on brand drugs will ultimately drop to 25% (100% minus 50% manufacturer discount minus 25% covered by plans) in 2020 and later years.

The following table summarizes the impact of the coverage gap proposal:

Year	Brands			Generic
	Plan Coverage in the Gap*	Manufacturer Discount	Effective Beneficiary Cost-Sharing	Effective Beneficiary Cost-Sharing
2010	0%	N/A	100%	100%
2011	0%	50%	50%	93%
2012	0%	50%	50%	86%
2013	2.5%	50%	47.5%	79%
2014	2.5%	50%	47.5%	72%
2015	5%	50%	45%	65%
2016	5%	50%	45%	58%
2017	10%	50%	40%	51%
2018	15%	50%	35%	44%
2019	20%	50%	30%	37%
2020	25%	50%	25%	25%

*Expanded plan coverage will result in higher premiums, which are paid by the federal government and beneficiaries.

Plans will now be permitted to charge co-payments that are actuarially equivalent to the 25 percent co-insurance, similarly to how they do now in the rest of the benefit. Furthermore, while the bill does not alter the initial coverage limit or the true-out-of-pocket limit (TrOOP), the catastrophic coverage level will rise because the government is covering part of the cost of drugs in the donut hole.

The Senate bill also had a provision that would have increased the initial coverage limit for 2010 by \$500. The reconciliation bill repeals that provision, and instead provides a one-time payment of \$250 to anyone who reaches the coverage gap in 2010.

A Closer Look: Medicare Advantage Payment Rates

The reconciliation package phases-in new Medicare Advantage regionally-adjusted benchmark amounts. The base payment amount will be equal to county fee-for-services (FFS) costs multiplied by a given percentage. Counties will be ranked into quartiles according to FFS spending, and the percentage multipliers will be set as follows:

- Highest spending quartile: 95%
- Second highest spending quartile: 100%
- Third highest spending quartile: 107.5%
- Lowest spending quartile: 115%

Medicare Advantage payments will be frozen in 2011 and new benchmarks will be phased-in starting in 2012.

Plans can receive bonus payments beginning in 2012 if they have quality ratings of four stars or higher (on a five star rating system). The bill also reduces rebates to all plans beginning in 2012 and sets rebates differentially by quality rating of the plan. Further, it requires the Secretary to annually conduct an analysis of coding pattern differences and to adjust risk-scores accordingly. The adjustment from 2019 and subsequent years must be at least 5.7 percent. Finally, the bill would require Medicare Advantage plans to maintain a medical loss ratio of at least 85% beginning in 2014.

Key Provisions by Industry

The table below identifies key proposals in reconciliation bill for various healthcare industries.

Industry Sector	Policy Proposals in the President's Plan
Pharmaceutical Manufacturers	<ul style="list-style-type: none"> ■ Increases annual fee by \$4.8B over 10 years and delays start date to 2011 ■ Closes the Part D donut hole, but maintains 50% discounts ■ Eliminates 340B expansion to inpatient drugs ■ No changes to Senate proposals for AMP definition, comparative effectiveness research, follow-on-biologics, or Medicaid rebate expansions
Imaging and Medical Technology	<ul style="list-style-type: none"> ■ Changes medical device annual fee to a 2.9% excise tax on the first sale of a product and excludes Class 1 medical devices, eye-wear and certain over the counter products ■ Delays start date to 2011 ■ Increases the assumed utilization rate for imaging services
Health Plans	<ul style="list-style-type: none"> ■ Delays annual fee on health plans until 2014 ■ Sets MA benchmarks as a percent of FFS costs with bonus payments for quality and enrollee satisfaction ■ Imposes some insurance regulations on grandfathered plans ■ Delays the Cadillac tax and increases the income threshold ■ Increase individual mandate penalties for higher-income individuals
Providers	<ul style="list-style-type: none"> ■ Expanded fraud and abuse prevention ■ Lowers Medicare and Medicaid DSH cuts ■ Increases hospital market basket reductions ■ Removes Senate provision that eliminated market basket reductions based on coverage levels for inpatient and outpatient hospitals, LTACHs, IRFs, and psychiatric hospitals



Table 2. High-Level Comparison of Key Provisions between the Senate Patient Protection and Affordable Care Act (PPACA) and the Reconciliation Package (H.R. 4872)

Provision	Senate Approved PPACA, as approved 12/21/09	Reconciliation Package, as of 3/18/10	Commentary & Analysis
Public Option	<ul style="list-style-type: none"> No public plan OPM contracts with two private plans (at least one non-profit) to offer national or multi-state plans in exchanges 	<ul style="list-style-type: none"> No change 	<i>Consistent with the President's proposal, the bill does not include a public option in the exchange</i>
Insurance Cooperative	<ul style="list-style-type: none"> Allows states to offer a co-op plan through the exchange 	<ul style="list-style-type: none"> No change 	
Insurance Exchange	<ul style="list-style-type: none"> State-based exchanges for the individual market and separately for the small businesses with up to 100 employees 	<ul style="list-style-type: none"> No change 	<i>Maintains state-based exchanges with federal start-up funding</i>
Individual Mandate	<ul style="list-style-type: none"> Penalties are the greater of: <ul style="list-style-type: none"> \$95 in 2014, \$495 in 2015, \$750 in 2016 and indexed thereafter; or 0.5% of household income for 2014, 1.0% in 2015, 2.0 percent in 2016 and beyond 	<ul style="list-style-type: none"> Penalties are the greater of: <ul style="list-style-type: none"> \$95 in 2014, \$325 in 2015, \$695 in 2016 and indexed thereafter; or 1.0% of household income for 2014, 2.0% in 2015, 2.5% in 2016 and beyond Exempts individuals below the tax filing income threshold (\$18,700 for a couple in 2010) 	<p><i>Consistent with the President's proposal, makes the penalties more progressive.</i></p> <p><i>Low-income individuals may still decline coverage if tax credits are not adequate to make insurance affordable.</i></p>

Provision	Senate Approved PPACA, as approved 12/21/09	Reconciliation Package, as of 3/18/10	Commentary & Analysis
Employer Mandate	<ul style="list-style-type: none"> ■ Penalizes employers with 50 or more full-time workers who do not offer affordable coverage to their workers <ul style="list-style-type: none"> - Penalty is the lesser of \$3,000 for each employee receiving a tax credit or \$750 per full-time employee ■ Penalizes employers of 50 or more that require a waiting period before an employee can enroll in coverage as follows: <ul style="list-style-type: none"> - \$400 for any employee in a 30-60 day waiting period - \$600 for any employee in a 60-90 day period ■ Permits employees to receive a voucher equal to the amount of their employer premium contribution to be used toward the cost of coverage in an exchange 	<ul style="list-style-type: none"> ■ Revises the Senate employer penalties by subtracting the first 30 workers from each company's per-worker penalty calculation ■ Companies that do not offer coverage and have at least one employee receiving a premium subsidy must pay \$2,000 per employee ■ Companies that do offer coverage but have employees receiving subsidies through the exchange must pay \$3,000 per employee receiving the subsidy ■ Eliminates penalties for workers in a waiting period, but limits all waiting periods to 90 days ■ Counts part-time employees for the purpose of determining whether a company is a large-employer eligible for the penalties 	<p><i>Increases penalties on employers who do not offer coverage</i></p> <p><i>Does not change the penalty on employers who offer coverage but have workers receiving subsidies in the exchange</i></p> <p><i>Includes part-time workers when identifying qualified, large employers</i></p>
Insurance Market Reform	<ul style="list-style-type: none"> ■ 3:1 age rating ■ Requires plans to report MLR ■ Beginning in 2011, 85% MLR required for large groups and 80% MLR required for small and non-group plans (MLR requirements do not sunset) ■ Requires coverage of dependents up to age 26 ■ Prohibits annual or lifetime limits 	<ul style="list-style-type: none"> ■ Prohibits "grandfathered" plans from applying excessive waiting periods, imposing lifetime limits or rescinding coverage ■ Requires "grandfathered" plans to cover dependents up to age 26 	<p><i>Does not include the President's proposal to create a Health Insurance Rate Authority to oversee premium increases</i></p> <p><i>New requirements on grandfathered plans could raise premium rates for currently insured individuals</i></p>

Provision	Senate Approved PPACA, as approved 12/21/09	Reconciliation Package, as of 3/18/10	Commentary & Analysis
Taxes	<ul style="list-style-type: none"> ■ New Medicare payroll tax equal to 0.9% of wages beginning 2013 in excess of \$250,000 ■ 40% excise tax on employer-sponsored health coverage with a value over \$8,500 for individuals and \$23,000 for families beginning in 2013 	<ul style="list-style-type: none"> ■ Expands the Medicare payroll tax to include a 3.8% assessment on net investment income for individuals earning more than \$200,000 and couples earning more than \$250,000 ■ Delay excise tax on high-value insurance until 2018 <ul style="list-style-type: none"> - Tax applies to plans with a value of \$10,200 for an individual and \$27,500 for a family - Dollar thresholds indexed to CPI 	<p><i>As proposed by the President's plan, delays start and increases threshold for the "Cadillac" tax</i></p> <p><i>Reduces index amount for Cadillac tax, so it will have more impact over time</i></p> <p><i>Increases Medicare payroll tax to make-up for lost revenue</i></p>
Medicaid Expansion	<ul style="list-style-type: none"> ■ Requires states to expand to 133% FPL in 2014 ■ Increases FMAP to 100% for adult expansion populations in 2014 through 2016 for all states ■ Increases FMAP by 30.3% in 2017 and 31.3% in 2018 for certain "expansion" states and by 34.3% in 2017 and 33.3% in 2018 for non-expansion states <ul style="list-style-type: none"> - Expansion states defined as those with eligibility levels for parents and childless adults of at least 100% FPL at the time of enactment - Increases FMAP by 32.3% in 2019 for all states with a cap of 95%. ■ Nebraska is exempt from paying the state-share for newly eligible individuals 	<ul style="list-style-type: none"> ■ Revises the federal funding for non-expansion Medicaid states to 100% in 2014-16 phasing down to 90% in 2020 ■ Provides federal assistance to expansion states for childless adult coverage beginning in 2014 <ul style="list-style-type: none"> - FMAP will gradually increase to reach 90% by 2010 (to converge with non-expansion state rates) 	<p><i>Eliminates the exemption for Nebraska's Medicaid program and increases federal funding for all states</i></p> <p><i>Rewards states that have already expanded their Medicaid programs by increasing the FMAP for non-expansion populations</i></p>
Medicaid Rebates	<ul style="list-style-type: none"> ■ Increases rebates to 23.1% of AMP for brand drugs and 13% of AMP for generics ■ Extends rebates to Medicaid managed care organizations ■ Applies additional rebates to new formulations ■ All of funds attributable to rebate increase go to the federal government 	<ul style="list-style-type: none"> ■ Applies the additional rebate for new formulations only to oral solid dosage forms of a drug 	

Provision	Senate Approved PPACA, as approved 12/21/09	Reconciliation Package, as of 3/18/10	Commentary & Analysis
340B	<ul style="list-style-type: none"> ▪ Extends 340B discounts to new hospital types ▪ Extends discounts to inpatient drugs 	<ul style="list-style-type: none"> ▪ Repeals the Senate provision that would have expanded 340B to inpatient drugs 	<p><i>Manufacturers were successful in getting the 340B expansion to inpatient settings eliminated from the bill</i></p>
Medicare Advantage	<ul style="list-style-type: none"> ▪ Sets payment benchmarks based on competitive bidding, starting in 2015 with a transition period from 2011-2014 ▪ Allows MA plans to grandfather supplemental benefits for current enrollees in areas where average plan bids are at or below 75% of FFS costs, starting in 2012; provides temporary funding for transitional extra benefits for certain other areas ▪ Creates two quality bonus payments for MA plans, starting in 2014, with a combined maximum payment of 6% of the U.S. Per Capita Costs of Medicare ▪ Revises MA plan service areas to be based on CBSAs for urban areas and counties for rural areas 	<ul style="list-style-type: none"> ▪ Sets benchmarks based on a percent of current average FFS costs, phasing-in benchmarks over an unspecified period ▪ Offers quality bonus payments for MA plans based on quality and enrollee satisfaction ▪ Rebate payments for differences between the benchmark and a plan's bid will vary based on the plan's quality rating ▪ Requires a coding intensity adjustment to reflect unjustified risk score growth in MA ▪ No provision to extrapolate risk adjustment data validation (RADV) audits results 	<p><i>Compromise policy between the House and Senate bill</i></p> <p><i>Payment changes expected to yield higher savings than the Senate bill due to required coding intensity adjustment</i></p>
Part D Donut Hole	<ul style="list-style-type: none"> ▪ 50% discount for branded drugs in donut hole beginning in 2010 ▪ Increases the initial coverage limit by \$500 	<ul style="list-style-type: none"> ▪ Eliminates the Part D donut hole by 2020 by: <ul style="list-style-type: none"> - Requiring manufacturers to contribute 50% discounts for all drugs in the gap - Requiring plans to phase-down the remaining beneficiary co-insurance requirement from 50% to 25% ▪ Drops the \$500 increase to the initial coverage limit and offers a \$250 rebate to beneficiaries who hit the donut hole in 2010 	<p><i>Manufacturers will be required to pay the 50% discounts in perpetuity</i></p> <p><i>Part D premiums are expected to rise as a result of the donut hole closure</i></p>

Provision	Senate Approved PPACA, as approved 12/21/09	Reconciliation Package, as of 3/18/10	Commentary & Analysis
Industry Fees	<ul style="list-style-type: none"> ▪ Annual industry fee of \$2.3B for pharmaceutical manufacturers of brand name drugs ▪ Annual \$2B fee for medical device manufacturers starting in 2011, fee increases to \$3B per year in 2018 ▪ Annual fee on health plans phases in from \$2B in 2011 to \$10B per year in 2017; excludes ASO/TPA revenue from allocation of the fee 	<ul style="list-style-type: none"> ▪ Increases fee on pharmaceutical manufacturers to \$28B over 10 years; delays start date to 2011 ▪ Delays implementation of the device manufacturer fee until 2013; converts to a 2.9% excise tax administered by IRS, exempts Class 1 devices, eye- wear and certain over-the-counter products ▪ Delays implementation of annual fee on health plans until 2014; excludes 50% of net premiums for non-profit plans 	<p><i>Increases manufacturer contributions by \$10B over 10 years</i></p>
Follow-on-Biologics	<ul style="list-style-type: none"> ▪ Establishes 12 years exclusivity; additional 6 months for pediatric studies and orphan use ▪ Defines interchangeable biologic product as a biologic that may be substituted for the reference product without the intervention of the provider who prescribed the reference product ▪ Biosimilar biologics will be paid at their own ASP plus 6% of the reference biologic's ASP 	<ul style="list-style-type: none"> ▪ No change 	
CER	<ul style="list-style-type: none"> ▪ Creates non-profit non-governmental corporation to set priorities and conduct CER, contract preference given to AHRQ and NIH ▪ Establishes explicit process to disseminate findings and archive government-funded CER findings for future research ▪ Prohibits use of quality-adjusted life year as threshold for establishing cost-effectiveness 	<ul style="list-style-type: none"> ▪ No change 	
Imaging	<ul style="list-style-type: none"> ▪ Phases in the imaging utilization rate for high cost devices 	<ul style="list-style-type: none"> ▪ Increases the imaging utilization rate for high cost devices to 75 percent 	

Provision	Senate Approved PPACA, as approved 12/21/09	Reconciliation Package, as of 3/18/10	Commentary & Analysis
Delivery Reform	<ul style="list-style-type: none"> ▪ Creates new CMS Center for Medicare and Medicaid Payment Innovation ▪ Creates new Independent Payment Advisory Board ▪ Establishes Medicare Shared Savings (i.e. Accountable Care Organization) program; extends current Gainsharing Demonstration ▪ Creates state grants for community based “health teams” to support implementation of patient-centered medical homes; allocates funds for state Medicaid to implement medical home models ▪ Requires Secretary to deliver a national quality improvement strategy by January 1, 2011, with \$95M annually for quality measure development and use 	<ul style="list-style-type: none"> ▪ No change 	
Prevention and Wellness	<ul style="list-style-type: none"> ▪ Establishes funds to conduct research and implement programs starting in 2010 ▪ Expands coverage of preventive services to include annual wellness visits, waives most coinsurance requirements, and allows Secretary to expand number of preventive services covered by Medicare and Medicaid furnished on or after January 1, 2010 ▪ Strengthens the Part D medication therapy management (MTM) program ▪ Creates the Cures Acceleration Network within NIH that awards grants to develop medical products and therapies for high need cures 	<ul style="list-style-type: none"> ▪ No change 	
Facility Payment	<ul style="list-style-type: none"> ▪ Market basket reductions for inpatient hospitals, LTACHs, IRFs, hospice, and home health ▪ Delays implementation of RUG-IV for SNFs 	<ul style="list-style-type: none"> ▪ Reduces DSH cuts from the Senate bill and increases inpatient hospital market basket reductions in addition to the productivity adjustment from FY 2014 – 2019. ▪ Removes the Senate provision that eliminates the additional market basket for inpatient and outpatient hospitals, LTACHs, IRFs and psych hospitals 	

Provision	Senate Approved PPACA, as approved 12/21/09	Reconciliation Package, as of 3/18/10	Commentary & Analysis
Physician Payment	▪ No physician fix	▪ No physician fix	<i>The House approved a one-month physician payment fix through the end of April</i>