

Client Alert

New Consolidated Appropriations Act Yields Tax Delays, Funding Limitations, & Medicare/Medicaid Changes

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On December 18, 2015, President Obama signed the Consolidated Appropriations Act, 2016 (H.R. 2029) into law. The \$1.1 trillion dollar appropriations and tax law will fund the government through 2016. The bipartisan legislation delays three health care taxes, limits the availability of funds for the temporary risk corridors program, and tweaks Medicare and Medicaid payments and funding.

Health Insurance Tax Suspended for 2017

The Act suspends for the year 2017 the annual health insurance provider fee, sometimes referred to as the health insurance tax or "HIT," which was imposed by Section 9010 of the Affordable Care Act (ACA). The HIT took effect in 2014 and will continue through 2016. The Act imposes a 1-year moratorium from January 1, 2017 until December 31, 2017. Revenues from the HIT have been used to offset some of the costs of the ACA.

Section 9010 imposes an annual excise tax on insurers in the business of providing health insurance for United States health risks. An insurer's tax liability is based on the proportion of its net premiums written (subject to certain exclusions and limitations) to a statutorily prescribed target amount that increases until 2018, after which the target amount will be increased by the rate of premium growth as defined in I.R.C. § 36B(b)(3)(A)(ii). The target amount for 2015 and 2016 is \$11.3 billion. Insurers generally include the cost of the HIT tax in premiums, so the tax raises the cost of health insurance to consumers and employers. Now that the tax has been suspended for 2017, advocates are expected to push for its permanent elimination.

Cadillac Plan Tax Delayed until 2020, Made Deductible

The Act delays the tax on "high cost employer-sponsored health coverage" (the "Cadillac Plan" tax) for two years, until 2020. The Cadillac Plan tax, which is part of the ACA, imposes a 40 percent tax on any "excess benefits" provided under employer-sponsored coverage. (See I.R.C. § 4980I.) It applies to insured and self-insured health plans, as well as federal and state governmental plans. The tax is calculated as 40 percent of the excess cost of "employer-sponsored coverage" over statutory thresholds. Employer-sponsored coverage can include the cost of a group health plan, as well as flexible savings accounts, health savings accounts, on-site medical clinics, and other coverage. The statutory thresholds are to be set annually from base values of \$10,200 (for self-only coverage) and \$27,500 (for other than self-only coverage), adjusted to reflect the age and gender composition of an employer's population. Because of the broad scope of "employer-sponsored coverage" and the growth trends in health care costs, the Cadillac Plan tax is expected to reach a large proportion of employers in coming years.

In addition to delaying the tax, the Act also made the Cadillac Plan Tax deductible for income tax purposes. As originally enacted, the Cadillac Plan tax was a nondeductible excise tax. This is a significant shift, and a significant relaxation of rules for employers and insurers. It is anticipated that insurers and third party administrators, if they are responsible for payment of the tax, would pass the cost on to the employers. Insurers and third-party administrators who receive reimbursement for a non-deductible excise tax from an employer would thereby realize net taxable income. Hence full reimbursement would actually include not only payment for the excise tax itself, but also a "gross up" to account for the taxes due on this new taxable income. The result would be that "full reimbursement" would cost employers around 50-60 percent, rather than the statutory excise tax rate of 40 percent. By making the Cadillac Plan tax deductible, the Act ensures not only that entities who pay the tax will receive a deduction for it, but also that employers will be charged only the statutory rate in any "full reimbursement" imposed by their service providers. Of course, practical impact of this change is unclear, given that the further delay in the imposition of the Cadillac Plan tax raises questions as to whether the tax will actually survive to be imposed in 2020, or rather it will (as has been attempted numerous times by various acts supported by members of both parties) be repealed wholesale.

Medical Device Tax Suspended for 2016-2017

The Act suspends by two years the medical device tax created to help pay for the ACA, prohibiting collection of the tax from January 1, 2016 to December 31, 2017. The federal government began collecting the 2.3 percent tax on medical devices, such as pacemakers and ventilators, in January 2013. The ACA generally defines a medical device subject to the tax as any device listed with the Food & Drug Administration (FDA) under section 510(j) of the Federal Food, Drug, and Cosmetic Act and 21 C.F.R. Part 807. Certain devices, such as eyeglasses, contact lenses and hearing aids are exempt from the tax. The two year suspension is expected to cost \$3.4 billion, according to the Joint Committee on Taxation.

The tax was expected to raise \$30 billion over 10 years to help pay for the ACA, according to Congressional Budget Office projections. A recent I.R.S. Inspector General Audit found that a majority of medical device companies were not paying the tax, leading to a shortfall in federal revenues. The tax was extremely unpopular in the medical device industry and advocates asserted that the tax stifled innovation. Advocates indicate that they will continue to press Congress in 2016 to permanently eliminate the tax.

Risk Corridors Funding Limited

The Act continues Congressional efforts to limit the availability of funding for ACA Section 1342's temporary risk corridors program. As in last year's Consolidated and Further Continuing Appropriations Act, 2015 (also known as "Cromnibus"), the Act prohibits CMS from using trust funds and other accounts to fund risk corridors payments. The risk corridors program calls for plans with lower than expected claims and other allowable costs to make payments into the program and provides for HHS to make payments to plans with higher than expected claims and other allowable costs. Although nothing in the ACA requires the risk corridors program to be budget neutral, many in Congress have sought to limit risk corridor payments to the amount of money collected from insurers under the program.

HHS has stated that in the event of a shortfall, "HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations." On October 1, 2015, HHS announced that plans requested about \$2.87 billion in risk corridor payments for the 2014 plan year, but that it would only pay out approximately \$362 million. This is roughly a 12.6 percent payment rate, higher than the less than 10 percent payment rate forecast by Standard & Poor's Ratings Services in May 2015, but well short of amounts due to plans.

Notwithstanding Congress's refusal to appropriate funds for the risk corridors program, HHS has repeatedly acknowledged that the federal government remains on the hook for payments to insurers. Most recently, on November 19, 2015, HHS explained that, "HHS is recording those amounts that remain unpaid following our 12.6 percent payment this winter as a fiscal year 2015 obligation of the United States Government for which full payment is required."

If Congress continues to fail to appropriate sufficient funds to HHS for the risk corridors program, insurers could sue to collect, asserting that the amounts are an enforceable obligation against the U.S. Treasury under the Tucker Act. The Tucker Act, 28 U.S.C. § 1491, provides private entities that have claims for damages based on Federal contracts, statutes or regulations a right to sue for recovery in the Court of Federal Claims. Under the Tucker Act, the Court of Federal Claims has jurisdiction over claims against the United States founded upon the Constitution, a federal statute or regulation, or an express or implied contract with the United States. To state a cause of action under the Tucker Act, a plaintiff must identify a substantive right to money damages against the United States for which it has standing to sue. There are strong grounds for viewing ACA Section 1342 as creating a right to payment. Plaintiffs would also have to demonstrate that from a timing standpoint and otherwise the government has breached its obligations. Amounts awarded under the Tucker Act in the Court of Federal Claims are not subject to congressional appropriation limitations on agency funding and can be collected from the Department of the Treasury.

Changes Made to Medicare & Medicaid Funding and Payment

The Act includes the Department of Health and Human Services Appropriations Act of 2016, which tweaks several Medicare and Medicaid payment and funding provisions.

The funding provisions include:

- Allocating approximately \$500 million for the Medicare Integrity Program at CMS to conduct oversight activities for Medicare Advantage and the Medicare Prescription Drug Program. Over \$125 million in program integrity funds are designated for the Department of Health and Human Services Office of Inspector General and the Department of Justice to carry out fraud and abuse activities. Program integrity includes the following activities: (1) conducting provider audits; (2) reviewing claims for medical necessity; (3) identifying and investigating fraud; (4) ensuring that Medicare pays only for services for which it has primary responsibility; (5) educating providers on Medicare billing procedures; and (6) identifying improper billing practices that affect both Medicare and Medicaid.

- Denying the Medicare Advantage Program access to appropriated funds if the Secretary denies participation to an "otherwise eligible entity" because the entity refuses to provide, pay for, or refer for abortions.
- Reducing funds available in the Medicare Improvement Fund (MIF) for improvements in the Medicare fee-for-service program for services furnished during and after fiscal year 2020. The cuts to Medicare funding help offset the costs of reauthorizing the World Trade Center Health Program.

Payment changes include:

- Incentivizing the use of digital radiography over traditional x-ray imaging by reducing the Medicare hospital outpatient prospective payment system and physician fee schedule payment for the technical component of film x-rays by 20 percent beginning in 2017.
- Limiting state Medicaid durable medical equipment reimbursement amounts to the applicable Medicare fee-for-service payment rates beginning January 1, 2019.

Conclusion

The suspension and/or delay of the HIT, Cadillac Plan and medical device taxes raise the possibility that Congress may eventually eliminate these entirely. These taxes were imposed in part to provide funding for the ACA, so the Act means that other funds will be needed to pay for ACA programs. The Cadillac Tax has also been viewed as a cost containment vehicle, by encouraging employers to employ contribution levels and benefit designs that make employees have more "skin in the game." The restrictions on the use of funds for the Risk Corridor program have already had financial repercussions for insurers offering ACA products. The net effect of the Act is to raise questions about various aspects of ACA governance of insurance programs. The future of the ACA should thus continue to be a major issue in the current political cycle.

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