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S. 1932, The Deficit Reduction Act of 2005 and Managed Care Organizations

Today, the House approved S. 1932, The Deficit Reduction Act of 2005. Today's action clears the \$38.8 billion budget reconciliation measure for signature by the President. Included within S. 1932 are several provisions related to risk adjustment, provider tax, and high-risk health insurance pool programs which will impact the operations of managed care providers in 2006.

Phase-Out of Risk Adjustment, Section 5301

Current Law – Medicare Advantage payment rates are risk adjusted to control for the variation in the cost of providing health care among beneficiaries. Rates are adjusted by demographic and health status indicators. In the report language to the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Congress urged the Secretary of HHS to implement a more clinically-based risk adjustment methodology without reducing overall payments to plans. To keep payments from being reduced overall, the Secretary applied a budget neutrality adjustment to the risk adjusted rates. However, the Secretary has proposed to phase-out the budget neutrality adjustment citing studies that show a difference in the reported health status of Medicare Advantage enrollees compared to the reported health status of beneficiaries in traditional Medicare.

Change – S. 1932 codifies the phase-out of the budget neutrality factor over 2006 to 2010 and outlines the adjustments that can be made to that factor. Under the provision, the HHS Secretary must conduct an analysis to identify differences in coding patterns between Medicare Advantage plans and fee for service. To the extent that the Secretary identifies any differences, they are to be incorporated into calculations of the risk rates and the budget neutrality factor in 2008, 2009, and 2010. The intention is that any adjustments made for differences in coding patterns be

made for differences resulting from inaccurate coding. S. 1932 makes no permanent change to Medicare Advantage payment calculations.

Managed Care Organization Provider Tax, Section 6051

Current Law – A state's ability to use provider-specific taxes to fund Medicaid expenditures is limited. If a state establishes provider-specific taxes to fund the state's share of program costs, reimbursement of the federal share will not be available unless the tax program meets the following three rules: the taxes collected cannot exceed 25 percent of the state (or non-federal) share of Medicaid expenditures; the state cannot provide a guarantee to the providers that the taxes will be returned to them; and the tax must be 'broad-based.' Medicaid managed care organizations ("MCOs") are identified as a separate class of providers for the purposes of determining if a tax is broad-based.

Change – S. 1932 expands the Medicaid MCO provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both Medicaid and non-Medicaid MCOs. The provision becomes effective upon enactment except in states with taxes based on the current law Medicaid MCO provider class as of December 8, 2005. In those states, the provision becomes effective on October 1, 2009.

State High Risk Health Insurance Pool Funding, Section 6202

Current Law – A majority of states have established high-risk health insurance pool programs as one approach to reduce the number of uninsured persons. These programs target individuals who cannot obtain or afford health insurance in the private health insurance market, primarily because of pre-existing health conditions. Many states also use their high-risk pools to provide

access to health insurance to individuals eligible under the guaranteed issue and portability provisions of HIPAA. In general, high-risk pools are operated through state-established nonprofit organizations that contract with private insurance companies to collect premiums, administer benefits, and pay claims. These programs tend to be small and enroll a small percentage of the uninsured. As of December 2004, 33 states operate high risk health insurance pool programs. Authorizing legislation for federal funding of these pools expired September 30, 2005.

Change – S. 1932 would appropriate, for FY2006, \$75 million for the losses incurred by a State in connection with the operation of their qualified high risk pool. There is also \$15 million in FY2006 appropriated to fund seed grants to States to create, and initially fund, a high risk pool. This funding will also apply upon the enactment of the State High Risk Pool Funding Extension Act of 2005

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