



## **BRIEF LEGISLATIVE SUMMARY (03/25/10)**

**Senate Health Reform Bill: HR 3590 Patient Protection and Affordable Care Act**  
**HR 4872 Budget Reconciliation Bill: Affordable Health Care for America**

The health care reform legislation mandates that all individuals purchase health insurance. While there is not an explicit employer mandate to provide coverage, the bill imposes penalties on large employers that do not provide insurance coverage to their employees. The bill covers 80% of California's uninsured and 95% of the nation's uninsured through tax credits and a Medicaid expansion. California has at least 6.5 million uninsured 1.4 million of whom are undocumented or new legal immigrants who will not be covered by this bill. Of the 5.1 million uninsured Californians who are eligible, 1.7 million will be enrolled in Medicaid and 3.2 million uninsured will be able to choose private health plans in or out of the Health Insurance Exchange.

The Medicaid expansion will be 100% federally financed initially, phasing down to 90% in 2020 and later years. The legislation includes a Medicaid primary care physician rate increase to Medicare levels for E&M services and immunizations for 2013 and 2014.

The bill establishes a Health Insurance Exchange which will offer a broad choice of private health plans and physicians. The exchange will be state-based, not national. Two-thirds of the uninsured covered by this bill will enroll in private health plans. Everyone will have the system available to Members of Congress. And patients may continue to privately contract with non-contracted physicians of their choice.

There are significant initiatives to stop insurance industry abuses. The bill requires insurers to direct 85% of revenue to direct patient care rather than overhead and profit. Plans must have adequate provider networks. And there is a requirement to reduce physician billing hassles through administrative simplification. Insurers will be prohibited from denying coverage to those with pre-existing conditions and from rescinding coverage when a patient becomes ill.

The final version of the bill includes a 10% Medicare bonus for certain primary care services provided by primary care physicians over five years. There is also a 10% Medicare bonus for general surgeons practicing in rural areas over five years, bonuses for physicians running medical homes, and bonuses for physicians who coordinate care. The quality reporting programs are all voluntary for 4 years with 0.5-1% bonuses. The proposed Accountable Care Organizations provide a pathway to anti-trust relief, which would allow physicians who collaborate to have stronger negotiating power with health plans within Medicare and the private sector. There are cuts for advanced imaging services, although they were reduced from the original bill, and a ban on future physician-owned hospitals. The Medicare Advantage plans will be cut by \$130 billion, but there are bonuses for plans who meet quality standards. The direct contracting provision for medical groups was not included in the final bill. The bill includes substantial funding for prevention, wellness and

public health programs. It also makes significant investments in physician training and workforce programs.

Unfortunately, the bill does not include the California GPCI fix, which would have updated California's Medicare payment locality borders while holding the rural counties harmless from cuts for five years. It was pulled from the bill with all of the other single-state favors (ala the Ben Nelson Nebraska Cornhusker Medicaid deal). CMA has commitments from our House leaders to include the GPCI fix in the Medicare SGR bill later this year.

And while the House passed legislation to repeal the Medicare SGR, the Senate has yet to adopt a permanent solution and send it to the President for signature. Organized medicine will have to keep working to get the final repeal this year. Recently, the AMA has been involved in high-level negotiations with the White House and Senate Democratic leaders over the Medicare SGR issues. They are hoping to announce an agreement this year

The most threatening part of the bill is the establishment of an Independent Medicare Payment Advisory Board (IPAB) appointed by the President. It takes away Congress' accountability to physicians and seniors in the Medicare program. The IPAB is mandated to recommend Medicare reforms and make cuts if Medicare spending exceeds general health care spending. However, as long as the SGR is in effect, physicians will not be subject to IPAB cuts. But physicians face cuts – either from the SGR or the IPAB.

The Parliamentarian ruled all changes to the IPAB out of order, so our leaders were not able to adopt IPAB changes in the final reconciliation bill. Our House Democratic leaders, Speaker Pelosi, Chairman Stark and Chairman Waxman all fought the IPAB but it has been a major priority for the President and the Senate. These leaders have vowed to enact subsequent legislation to eliminate or seriously weaken the IPAB before it takes effect in 2015.

Finally, there are grants to states (that have not been able to enact MICRA), to test alternative medical liability reforms. Further liability relief for California physicians was not forthcoming because we enjoy the strongest law in the country. Our major objective was to protect MICRA and ensure it was not undermined.

The bill is financed with a combination of Medicare cuts and taxes. Health plans, pharma, medical device manufacturers, hospitals, home health and nursing homes face big cuts. There are also new fees on health plans, pharma, and the device manufacturers. Starting in 2018, there will be a "Cadillac" tax on health plans offering high-end benefits and an increase in the Medicare tax on high income earners and some net capital gains investment income. The non-partisan Congressional Budget Office (CBO) estimates the bill will cost \$940 billion and will reduce the deficit by \$138 billion in the first ten years and \$1.2 trillion in the second decade.



## **DETAILED LEGISLATIVE SUMMARY (03/24/10)**

**Senate Health Reform Bill: HR 3590 Patient Protection and Affordable Care Act**  
**HR 4872 Budget Reconciliation Bill: Affordable Health Care for America**

**(Most provisions take effect in 2014 unless otherwise indicated.)**

### **COVERAGE**

**Individual Mandate** – penalties up to 10% of income for those who do not purchase insurance;

**No Employer Mandate** but substantial fees on large employers who do not provide coverage. Immediate temporary high-risk pool with subsidized premiums for low-income uninsured with pre-existing conditions who have been denied health care coverage. (2010)

Temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (2010)

### **Currently Insured:**

If you like your insurance, you can keep it. Grandfathers most existing coverage.

### **Uninsured:**

Covers 80% of Californian's 6.5 million uninsured;

Does not cover 1.4 million undocumented or new legal immigrants.

Covers 2.3 million (incomes between 133% FPL-400% of FPL; \$28,665 and \$88,200 for a family of four) through private insurance.

Covers another 1 million who have incomes above 400% of FPL through private insurance.

Allows parents to continue coverage for children up to age 26. (2010)

Establishes catastrophic-only coverage for those up to 30 years of age.

Covers 1.7 million Californians (incomes up to 133% of FPL \$28,665) in Medi-Cal.  
100% federal financing phased down to 90% in 2020. Enhanced federal match in expansion states.

Tax credits for small employers to cover 637,700 California small business employees.

Tax credits to help low-income families afford premiums based on sliding fee scale linked to income.

**EXCHANGE** State-based Health Insurance Exchanges established to provide the uninsured with a choice of private health plans, benefit packages and doctors. This exchange is modeled after the Federal Employees Health Plan.

No Public Plan in the Exchange.

Four essential plan benefit categories: Bronze, Silver, Gold and Platinum with different cost-sharing requirements.

Allows Coops

In 2016, Multi-state compacts to allow insurers to sell policies across state lines implemented. Regulations due by 2013.

**INSURANCE INDUSTRY REFORMS - Effective in 2010)**

Requires health plans to spend 85% of revenue on direct patient care vs profit and overhead.

Requires adequate provider networks.

Requires plans to publicly disclose information on claims payment policies, enrollment, denials, rating practices, out of network cost-sharing and enrollee rights.

Prohibits plans from denying coverage for pre-existing conditions.

Prohibits plans from rescinding coverage when a patient becomes ill.

Prohibits plans from setting annual or life-time limits on benefits.

Modified community rating limits variation only on age, geographic area, tobacco use and family size. (2014)

**Prevention and Wellness**

National strategy to promote prevention, wellness and public health with additional funding.

**Comparative Effectiveness Research**

Establishes independent, non-profit CER institute to support clinical research on comparative clinical effectiveness. Board of Governors with four physician representatives. Prohibits use of research for coverage, payment or policy recommendations.

**MEDICAID**

Provides an increase in Medicaid reimbursement rates for primary care physicians (internists, family physicians and pediatricians) up to Medicare levels for E&M services and immunizations in 2013 and 2014.

**MEDICARE**

**Primary Care Bonus**

- 10% bonus payments for internists, geriatricians, family physicians and pediatricians over 5 years: 2011-2015 for whom primary care services (HCPCS codes 99201-99215; 99304-99340; and 99341-99350) account for at least 60% of Medicare allowed charges over a designated period of time. The bonus would be paid on a monthly or quarterly basis for each service that qualifies for payment.

### **Rural General Surgeons Bonus**

- 10% bonus payment for general surgeons practicing in health professional shortage areas over 5 years: 2011-2015.

Medicare Advantage Health Plans: Phases-in fiscal neutrality for Medicare FFS and MA. Sets MA payment based on average of bids from MA plans in each market area. Establishes a quality bonus for care coordination, care mgt and quality. \$130+ billion cut. (Starts in 2011)

### Payment for Imaging Services

In 2010, increases utilization rate assumption for advanced imaging equipment from 50%-65% and up to 75% in 2014 which reduces the reimbursement rates for imaging services.

### Hospital Programs

Reduces payments to hospitals by \$155 billion through DSH program.

Reduces payments to hospitals for hospital acquired conditions.

Demonstration programs to explore bundled payments for post-acute services.

Demonstration program to prevent readmissions.

### Medical Homes

Establishes a demonstration program for primary care medical homes for patients with multiple chronic conditions. Physicians could be eligible for shared savings if achieve quality outcomes, patient satisfaction and cost savings. NP and Pas may lead medical homes but only if state scope of practice laws allow it. CA law prohibits. (2011)

### Accountable Care Organizations

In 2012, CMS is required to establish a program to allow groups of physicians who report on quality and coordinate care to share in the savings (particularly from preventing unnecessary ER visits or hospitalizations) achieved in their region. ACOs can be small groups of loosely affiliated physicians or large organized groups. ACOs do not have to involve a hospital but physicians may share in the Part A hospital savings in their region. Because ACOs will be groups of physicians who are clinically and financially integrated, it establishes a path to anti-trust relief in both Medicare and the private sector.

Future Ban on Physician-Owned Hospitals: Effective December 31, 2010

### Medicare Part D Prescription Drug Program

Requires manufactures to provide a 50% discount to seniors for brand-name drugs and biologics.  
Closes the donut hole for drug coverage.  
Establishes a single, uniform exceptions and appeals process.

#### Independent Medicare Payment Advisory Board (IPAB)

Appointed by the President to reduce Medicare payment updates for physicians and other providers. IPAB mandated to reduce payments if Medicare spending exceeds health care spending. If the current SGR is in effect, physicians would not receive IPAB cuts. IPAB must take into consideration system-wide costs, patient access, utilization and quality of care by region, types of services and providers. Congress would only have 30 days to overturn recommendations with a supermajority 2/3 vote.

Changes to the IPAB were ruled out of order by the Parliamentarian for the Budget Reconciliation bill. However, due to other budget factors, the cuts the IPAB is required to make were reduced by 1/3 in the reconciliation bill. Speaker Pelosi, Chairman Stark and Chairman Waxman are all strongly opposed to the IPAB and have all vowed to revisit it in subsequent legislation.

#### Geographic Payment Issues

-There is no update to California's Medicare payment locality borders (CA GPCI fix).

It was removed from the bill with all the other single-state benefits.

House Democratic leaders have committed to include it in the SGR bill later this year.

-New practice expense floor for "frontier states" - \$6 billion for 5 rural states. (2010)

-New practice expense floor resulting in payment increases in rural states 2010-2012.

Mandates a study on the impact of practice expenses. Study results implemented 2012.

(CMA successful in getting a hold harmless for California and delaying implementation with a study for two years. In 2012, depending on the outcome of the study, some CA counties could benefit while other CA counties could receive as much as 8% reduction. Final impact unknown.)

-Medicare Cost/Quality Value Index Modifier: Effective 2015

Modifies physician payment based on level of spending. Physicians who spend less than national average paid a higher rate. Physicians who spend more than the national average paid a lower rate. CMA amendments ensure that rate is adjusted for geographic practice expense and socioeconomic status of the patients. Based on a MedPAC study, all CA counties except Los Angeles spend well below the national average. LA close to the national average and if other socioeconomic factors taken into consideration, such as income status of the patient population, LA will list below average.

#### Physician Utilization

5% penalty for physician utilization outliers eliminated. Continues the current program to provide confidential feedback to physicians comparing their utilization and resources use to their peers. Public reporting of aggregate information only.

### Quality Reporting

Continues the current Medicare PQRI quality reporting program. Provides 0.5%-1% bonuses for physicians 2011-2013. Participation mandatory in 2014 with penalties for nonparticipation.

### Quality Improvement

Establishes CMS Innovation Center to test pilot models that improve quality and slow Medicare cost growth rate.

Provides funding for development of national strategy and priorities for performance improvement and dissemination of quality measures and best practices. The development of quality measures remains with the AMA's Quality consortium which is comprised of all medical specialty societies.

Requires Secretary to update outcomes measures for physicians and hospitals on acute and chronic diseases.

In 2013, requires public reporting of Medicare physician and private payer information related to PQRI and other factors such as care coordination, resource use and patient satisfaction. Data would meet certain safeguards (valid, risk-adjusted) and physicians would have prior opportunity to review the data. Requires appropriate attribution methodology, timely feedback and accurate systems that can provide reliable data. AMA and CMA worked to include multiple amendments to protect physician information and ensure that it is accurate based on the CCHRI experience in CA.

Fraud and Abuse: Multiple initiatives to curb fraud and abuse.

Medicare physician participation fee eliminated.

### Graduate Medical Education

Redistributes current unused residency slots for primary care and general surgery.

Allows for training in outpatient settings.

Allows teaching health centers to expand primary care residency programs.

### Health Care Workforce

Authorizes the National Health Care Workforce Commission to examine barriers to primary care careers, authorizes state grants, increased funding for NHSC scholarship and loan repayment program; easing of access to loans for primary care providers, funding for health professions and diversity programs; other support for pediatrics, mental health and public health.

### **OTHER Provisions**

#### Administrative Simplification to reduce physician billing hassles in private sector

Requires the Secretary to adopt a single set of rules for electronic transactions for eligibility verification, claims status, claims remittance/payment, claims attachments, and a rule to establish an electronic funds transfer standard within specified period of time.

### Medical Liability Reform

Authorizes grants to states (that have not been able to enact MICRA) to test alternatives.

Authorizes GAO to study whether practice guidelines and other payment incentive programs in the bill would result in new causes of action.

### **REVENUE SOURCES**

#### Cosmetic Surgery Tax Removed

#### Cadillac tax on plans that offer high-end health benefits in effect 2018

Increased the dollar threshold to \$10,200 for single coverage and \$27,500 for family coverage. Dollar thresholds indexed to inflation.

#### Increase in the Medicare tax on higher income earners.

Budget reconciliation bill also taxes net investment income and capital gains from certain sources. Currently, the Medicare tax does not apply to investment income. The Medicare tax on investment income does not apply if modified adjusted gross income is less than \$250,000 in the case of a joint return, or \$200,000 for a single return. Net investment income is interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). Net investment income is reduced by properly allocable deductions to such income.

#### Fees on health plans, pharma and medical device manufacturers.

#### Cuts to Medicare – Health plans, Hospitals, Pharma, Nursing Homes, Home Health.

CBO Projects deficit reduction over 20 years. \$138 billion in first 10 yrs; \$1 trillion in second decade. Slows rate of health care spending growth from 6%/yr to 5%/yr.