



ISMS Analysis of HR 3200, America's Affordable Health Choices Act of 2009

The following is an analysis of the House Tri-Committee health reform legislation, HR 3200, America's Affordable Health Choices Act of 2009. The legislation including amendments passed by each of the three committees contains provisions consistent with ISMS policies as well as some that conflict with ISMS policies. Some ISMS policies, such as comprehensive medical litigation reform, are virtually absent from the bill. In some instances, the impact of the bill cannot be easily determined. For example, a public plan option as called for in the legislation would reduce the number of uninsured, which is consistent with ISMS policies, but if payment rates are tied to Medicare, the end result could be inconsistent with other ISMS policies that support adequate compensation for physicians.

Sustainable Growth Rate

By far, the provision most favorable to physicians is the elimination of the SGR. This provision will cost \$239 billion and would avoid the 20.5% payment reduction for 2010. Starting in 2011 there would be two conversion factors, one for E/M and preventive services and one for all other services. There would be more favorable expenditure targets for future Medicare physician updates and efficiency bonus payments would be provided for physicians in low-cost localities. While ISMS supports elimination of the SGR, the proposal does not guarantee that future updates would keep pace with inflation. According to the AMA, the bill calls for other Medicare payment improvements for physicians, including:

- A five percent increase in Medicare payment rates for primary care physicians starting in 2011—with no offsetting rate cuts for other physician services—and a 10 percent increase for those practicing in primary care Health Professional Shortage Areas.
- A 5 percent bonus payment for physicians in localities with relatively low Medicare spending from 2011 through 2013.
- An extended work geographic practice cost index, or GPCI, floor for physicians in localities with low geographic adjustment factors. The floor would be extended through 2011, and \$8 billion for revised geographic adjustment factors would be provided.
- Extending the 5 percent mental health service add-on payment for psychiatrists for an additional two years.
- \$300 million for California physicians to revise Medicare payment localities in the state.
- \$1.5 billion for physicians who administer adult vaccines to provide Part B coverage for all vaccines recommended by the Advisory Committee on Immunization Practices.

- Timely feedback reports and an appeals process for physicians who participate in the Physician Quality Reporting Initiative (PQRI).
- Waiving all Medicare cost-sharing for preventive services.
- A demonstration project to provide grants to offer language services to patients with limited English proficiency.

Professional Liability Reform

ISMS has extensive and longstanding policy on the need for professional liability reform. ISMS policy recognizes the costs associated with medical liability are a significant portion of national health expenditures and should be included as an essential element in health care reform. The bill does not address this issue and is a serious shortcoming. {E&C - States are eligible to receive an incentive payment if states implement an alternative medical liability law that contains alternatives such as certificate of merit or early offer.} These reforms appear weak and fall far short of ISMS policies.

Antitrust Reform

Similar to professional liability reform, the bill does not address antitrust reform, which is discussed in ISMS Health Care Reform Principle 8.

Public Health Insurance Option

ISMS policy favors a pluralistic system that uses the current public-private system as a basis for reform. The public option plan will receive initial start up federal funding but is designed to compete on a level playing field with private plans. {E&C - The public health insurance option shall not receive any federal funds for purposes of insolvency.}

Initially, the public option payment rates for physicians who also participate in Medicare would be five percent above Medicare for the first three years and then rates would be set by an administrative process. Pediatricians and other specialists who typically do not participate in Medicare are also eligible for the increased rates. Physicians would be in one of two classes: preferred physicians who agree to accept payment rates as payment in full and non-preferred who would be allowed to charge according to the balance billing limitations in Medicare. Such payment limitations are inconsistent with ISMS policies in support of balance billing within Medicare. It is unclear the level of reimbursement after the first three years. Physicians who participate in Medicare are considered participating physicians in the public plan unless they opt out. {E&C - Payments in the proposed public plan option should be based on negotiated rates so that rates are not lower than Medicare.} The inclusion of negotiated rates is an improvement over rates based on Medicare; however, without antitrust reform it is unclear whether physicians will actually be able

to have meaningful negotiations. {E&C - Allows creation of nonprofit health insurance cooperatives to offer insurance through the exchange.}

The bill calls for the development of innovative payments such as for medical homes, bundling of services, and performance or utilization payments. It is unclear if the plan has an out of network benefit.

Health Insurance Market Reform and Health Insurance Exchange

The bill contains a number of market reforms designed to expand access to insurance such as guaranteed renewability, modified community rating, and elimination of pre-existing condition denials. ISMS has long standing policy in favor of measures to increase portability, which is a key benefit of the health insurance exchange. The goal of the exchange is to facilitate plan comparisons and make enrollment easier and offer a range of consumer protections. Increased transparency regarding covered services, cost-sharing, excluded services, and out-of-pocket limits would benefit patients and is consistent with ISMS Health Reform Principle 3.

The health insurance exchange will be the responsibility of the Health Choices Commissioner who will be appointed by the President. The Health Benefits Advisory Committee will be a private-public advisory committee responsible for recommending covered benefits for the plans offered through the exchange. They will make their recommendations to the Secretary of HHS. {E&L - The essential benefits package will include early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.} Coverage for preventive services is consistent with ISMS policy.

There will be four categories of standardized plans: Basic, Enhanced, Premium, and Premium Plus. Individuals without coverage and small employers with 20 or fewer employees are eligible to use the exchange. In the third year employers with more than 20 employees may be permitted to use the exchange. {E&C - Members of the armed forces and those that have TRICARE or VA coverage can use the exchange.}

The increased transparency that will allow comparison among the plans in the exchange will be a welcome improvement but offering only four types of standardized plans may not be consistent with ISMS Health Care Reform Policy 2, which stresses that it is up to the individual to determine what coverage best suits one's individual needs. This may be important consideration since the bill restricts individual insurance to those policies offered through the health insurance exchange. This would require all new individual policies to meet the requirements of the exchange.

Affordability Credits

The bill provides for premium assistance to purchase individual insurance through the Health Insurance Exchange for those up to 400% FPL and for those with employer provided insurance deemed not affordable. The credits are inversely related to income, which is consistent with ISMS Health Care Reform Principle 4.

Individual and Employer Mandates

The bill includes both individual and employer mandates with penalties if insurance is not obtained. The individual mandate has a penalty of 2.5% of income and the employer mandate applies to firms with payroll over \$250,000 and penalties up to 8% of payroll for larger firms. Requires employers to contribute at least 72.5% of the premium for single coverage and 65% for family coverage. {E&C - Assessment for employers changed to exempt employers with payroll less than \$500,000.}

ISMS does not have policy on an individual mandate although AMA policy calls for an individual mandate for those above 500% of FPL. ISMS has policy opposing employer mandates.

Physician-Owned Hospitals

The bill prevents construction of new physician owned hospitals and restricts expansion of existing hospitals. ISMS does not have specific policy on physician-owned hospitals.

Imaging Reductions

The bill includes payment reductions for imaging services that are estimated to reduce Medicare spending by \$4.3 billion.

Medical Home Pilot Program

The bill includes a medical home pilot. While the role of APNs in the medical home pilot would be governed by Illinois law requiring APNs to have collaborative agreements with physicians, the bill allows APNs to lead a medical home. A medical home pilot with physicians leading medical homes would be consistent with ISMS Health Care Reform Principle 7. {E&C - Adopt accountable care organizations, bundled payments, and medical home models on a large scale if pilots are successful at reducing costs.}

Comparative Effectiveness Research

ISMS Health Care Reform Principle 9 addresses comparative effectiveness research. The bill establishes a center within the Agency for Healthcare Research and Quality. The new entity should be independent with a substantial role for physicians. The ISMS principles oppose mandated protocols, which are not included in the legislation. Conducting the research would be consistent with ISMS health care reform principles. {E&C - Prohibit use of comparative effectiveness research to deny care or to make Medicare coverage decisions.} This amendment is consistent with ISMS opposition to mandated protocols. {W&M - Requires the Institute of Medicine to study geographic variation in health care spending and recommend strategies for addressing the variation.}

Graduate Medical Education

The bill directs the redistribution of vacant residency slots for training of primary care physicians. There are also provisions to encourage training in non-acute traditional settings. These efforts are a good start but more should be done to address predicted physician shortages in non primary care specialties. These GME provisions are consistent with ISMS discussions regarding potential workforce shortages and are in addition to the physician workforce enhancements outlined in another section of the bill.

Program Integrity and Enhanced Fraud and Abuse Penalties

The bill provides an additional \$100 million for Medicare fraud and abuse activities. Such funding should be used to support existing programs and for physician outreach rather than new programs. The new requirements will burden physicians with additional regulations. For example, the fraud provisions include requiring physicians to certify home health care and to use a payment modifier in conjunction with E/M visits when physicians order another service. These additional burdens should be opposed as they are in opposition to ISMS Health Care Reform Principle 10.

Medicaid Expansion

The bill changes Medicaid eligibility to allow for coverage of low income individuals below 133% federal poverty level (FPL), based solely on financial need. ISMS policy prefers expanding coverage via subsidies for the purchase of private health insurance and has policy in opposition to Medicaid expansion. The federal government would pay 100% of the costs of this expansion. {E&C - The enhanced physician payments and coverage expansion will be fully funded by the federal government through 2014 and beginning in year 2015 the federal contribution will decline to 90%.}

The increase in Medicaid primary care physician payments to match Medicare rates is very positive and is consistent with ISMS policy but ideally the payment increases should be applied to all physician services to be consistent with ISMS Health Care Reform Principle 8.

There are a number of proposals to expand preventive and wellness services for Medicaid patients including a medical home pilot, which are consistent with ISMS Health Care Reform Principle 7.

Workforce

The bill increases loan repayment benefits to a maximum of \$50,000 per year and allocates an additional \$3.9 billion to the National Health Service Corps (NHSC) in addition to a new loan repayment program for physicians that do not qualify to participate in the NHSC. There are additional loan funds available for primary care physicians but such funding should be available for all undersupplied specialties. There is also a health workforce assessment that will collect data on

the supply, diversity, and geographic distribution, and the bill authorizes \$2.2 billion for various workforce programs. These provisions are generally consistent with ISMS workforce discussions.

Prevention and Wellness

ISMS Health Care Reform Principle 7 discusses the need for health care education and prevention and wellness initiatives. The bill contains a number of prevention and wellness initiatives consistent with ISMS policy. In particular, the bill establishes a prevention and wellness trust to authorize appropriations of \$35 billion to fund prevention and wellness research and activities. There will also be a variety of grant programs focused on community based prevention and wellness programs. Additionally, the Secretary is required to submit a national wellness and prevention strategy designed to improve the nation's health. These provisions are consistent with ISMS Health Care Reform Principle 7.