



ISMS Analysis of the Patient Protection and Affordable Care Act (H.R. 3590) **(Senate Leadership Bill)**

The following is an analysis of the Senate leadership's bill, which passed the Senate on December 24, 2009. The bill includes several provisions that are consistent with ISMS policy, such as expanding access to affordable health insurance and health insurance market reforms; however, other ISMS policies, such as a permanent Medicare sustainable growth rate (SGR) fix, are absent from the legislation. Additionally, while the legislation contains demonstration projects for alternative liability reforms, the legislation does not contain comprehensive medical litigation reform. Also, other items such as penalties for not participating in Medicare quality measurement programs and public reporting of quality data are of serious concern to ISMS.

Medicare Sustainable Growth Rate Formula

The legislation does not address the 21 percent Medicare physician pay cut for 2010. Separate legislation has recently been signed into law to delay the cut for 60 days. According to the AMA, the delay will give Congress time to pass legislation that will permanently fix the SGR. Without a repeal of the SGR, physicians will face payment cuts of 40 percent over the next several years.

Primary care physicians would be eligible for a 10 percent bonus on select evaluation and management codes, and general surgeons practicing in health professional shortage areas would be eligible for the bonus on major procedures. This is new money -- these bonuses would not be offset through reductions to other specialty codes.

Medical Liability Reform

ISMS has extensive and longstanding policy on the need for professional liability reform. ISMS policy recognizes that the costs associated with medical liability represent a significant portion of national health expenditures, and strong measures to reduce them should be included as an essential element in health care reform. The bill contains a provision that would allow the Department of Health and Human Services (HHS) to provide grants to states for developing and testing alternatives to the current civil litigation system. Patients can opt out of these alternatives. These reforms fall short of ISMS policies.

Antitrust Reform

The bill does not address antitrust reform, which is discussed in ISMS Health Care Reform Principle 8.

Health Insurance Co-Ops

ISMS policy favors a pluralistic system that uses the current public-private system as a basis for reform. The co-op plan will receive initial federal start-up funding of \$6 billion and is designed to compete with private plans. The co-ops would meet the same requirements as private insurance plans in the exchanges related to solvency, licensure, provider payments and network adequacy.

Health Insurance Market Reforms 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, prohibitions on annual and lifetime benefit limits, and elimination of pre-existing condition denials. Health plans will be required to report the percentage of their premium revenue that is spent on clinical services, activities that improve health care quality, and all other non-claims costs. Also, health plans will provide rebates to consumers if the amount spent on clinical services and quality is less than 85% of premium revenue for plans in the group market and 80% for plans in the individual market. The HHS Secretary, in consultation with the National Association of Insurance Commissioners, will establish uniform definitions for what constitutes clinical services and activities that improve health care quality.

States will be required to create health insurance exchanges for individuals and small businesses. The goal of the exchange is to facilitate portability, plan comparisons, make enrollment easier and offer a range of consumer protections. ISMS has long-standing policy in favor of measures that increase portability. 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. A small business with up to 100 employees would be able to purchase insurance through the exchange beginning in 2015, and in 2017 employers with more than 100 employees would be able to use the exchange. All state-licensed insurers in the individual and small group market would be required to participate in the exchange. Four benefit categories (bronze, silver, gold, platinum) will be available and all new policies issued in the individual or small group market would have to meet the exchange standards. A separate “young invincible” catastrophic-only policy would be available for those 30 years or younger.

The increased transparency that allows for comparison among the plans in the exchange is a welcome improvement, but if the exchanges only offer five types of plans with detailed requirements and benefit structures, such limitations in choice may not be consistent with ISMS Health Care Reform Principle 2, which stresses that it is up to the individual to determine what coverage best suits one’s individual needs. Also, it is not known what effect offering five standardized plans (and the associated regulations) will have on HSAs and high deductible plans, although there do not appear to be any provisions that would expand HSAs.

Individual and Employer Mandates

The bill includes an individual mandate with penalties if insurance is not obtained. The individual mandate has penalties that vary according to income but range from \$750 per individual and up to \$2,250 for families. Individuals who do not purchase coverage will pay the greater of the above amounts or 2% of household income, up to a cap of the national average bronze plan premium. The penalty will be phased in by 2016 and indexed in future years. The bill does not explicitly contain an employer mandate, but employers with more than 50 employees that do not offer coverage would pay a fee for each employee who receives subsidized coverage through the health exchange. ISMS does not have policy on an individual mandate, although AMA policy calls for an individual mandate for those above 500% of the federal poverty level (FPL). ISMS has policy opposing employer mandates.

Medicaid Expansion

The bill changes Medicaid eligibility to cover low-income individuals below 133% of the federal poverty level (FPL). Adults between 100-133% FPL have the option of obtaining subsidized coverage through the exchange. ISMS policy prefers expanding coverage via subsidies for the purchase of private health insurance and has policy in opposition to Medicaid expansion. States will receive federal funding to cover 100% of the costs of this expansion for three years, but by 2017, a new match rate will be phased in so that by 2019 virtually all states will receive a match rate increase of 32.3% for the newly eligible.

Tax Credits

Individuals and families with incomes up to 400% FPL are eligible for refundable and advanceable premium credits to purchase insurance through the health insurance exchanges. Such tax credits to purchase private insurance that are inversely related to income are consistent with ISMS Health Care Reform Principle 4.

Employers with less than 25 employees and less than \$40,000 in average annual wages can receive partial tax credits for purchasing health insurance for employees. The full amount of the credit would be available only to an employer with ten or fewer employees with average wages of less than \$20,000. Employers must contribute at least 50% of the premium cost.

Independent Payment Advisory Board

The bill establishes the Independent Payment Advisory Board that will submit legislative proposals to the President and Congress to reduce Medicare spending if spending exceeds growth rate targets. Hospitals are not subject to the Board cost reduction recommendations until 2020. The Board will also review overall national health spending and make recommendations that federal agencies can implement administratively or through federal or state legislation, or that the private sector can voluntarily implement. These proposals will be implemented unless Congress enacts legislation to override them.

Physician Quality Reporting Initiative

The bill establishes a new Medicare physician quality reporting initiative (PQRI) option. Physicians would be eligible for an incentive payment if they participate in an American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) program and complete a MOC practice assessment. Physicians who report quality data through an MOC process will receive an additional 0.5% PQRI bonus for three years. The existing PQRI program would change in that Medicare would be required to provide timely feedback and would establish an appeals process for physicians who participate in PQRI but do not qualify for incentive payments. Physicians who fail to participate successfully or who choose not to report in 2015 would face a 1.5% reduction in Medicare payments and 2% thereafter.

Quality Performance Reporting

The bill includes several quality improvement initiatives that will affect physicians. The bill includes public reporting of physician performance on quality measures such as PQRI measures as well as other factors such as health outcomes, continuity and care coordination, resource use, efficiency, patient safety, timeliness of care, and patient experience. Public reporting would begin in 2013 via a Physician Compare Internet website. The data are to be statistically valid and risk adjusted. Physicians will be given an opportunity to review data before it is made public, although it is unclear how disputes would be resolved when physicians identify discrepancies. The bill also directs the government to have the Physician Compare website include data from other payers to obtain a more accurate portrayal of physician performance. By 2015, the Secretary of HHS shall submit to Congress a report on the Physician Compare website and include information on collecting physician quality and efficiency data and on patient experience of care in support of value-based purchasing.

The HHS Secretary is directed to provide Medicare claims data to qualified entities for purposes of public provider performance reports. These qualified entities must meet government requirements and be qualified by the government to use claims data to evaluate the performance of providers on measures of quality, efficiency, effectiveness, and resource use. The bill states that these entities shall include claims data from other sources in their performance evaluation. Physicians must be given an opportunity to appeal and correct errors prior to public release. The bill also would develop a national quality improvement strategy and create processes for the development of quality measures for Medicare and Medicaid involving input from multiple stakeholders.

The bill requires Medicare to provide resource use reports to physicians, which would compare their resource use with that of other physicians. The reports would be based on an "episode grouper" methodology that combines services into an episode of care and assigns those services to an individual physician. This provision was originally an amendment introduced by Senator Cantwell that would have penalized physicians whose resource use was at or above the 90th percentile of utilization. These penalties have been removed from the bill. The episode grouper methodology is consistent with some value based purchasing arrangements where employers and health plans collect cost and quality information and share risk with providers.

The HHS Secretary may establish a demonstration program by 2019, to provide financial incentives to Medicare beneficiaries who are furnished services by high quality physicians, as determined by the HHS Secretary.

National Quality Improvement Strategy

The bill directs the federal government to establish a national quality improvement strategy to improve health care delivery and medical outcomes. As part of this effort, the government would identify gaps in quality measures or quality measures that need improvement.

Accountable care organizations (ACOs) would be eligible for incentive payments for meeting certain quality thresholds. ACOs are new entities authorized by this measure, which could be comprised of physicians, hospitals and other providers that have at least 5,000 beneficiaries assigned.

The bill creates an Innovation Center within Medicare to test and evaluate payment methodologies that slow Medicare cost growth and improve quality. Models to be tested include the patient-centered medical home, risk-based payments and varying physician payments based on adherence to appropriateness criteria for ordering diagnostic imaging services.

The bill requires the federal government to develop and test alternative bundled payment methodologies through pilot programs designed to improve coordination of care.

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.

Comparative Effectiveness Research

The bill establishes an independent non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors. The Institute shall insure that the recommendations will not be construed as mandates for practice guidelines, coverage recommendations, payment or policy recommendations. ISMS Health Care Reform Principle 9 addresses comparative effectiveness research (CER). As long as CER is not mandated and physicians are free to tailor care to each individual patient's needs, this provision is consistent with ISMS policy.

Graduate Medical Education

The bill authorizes the redistribution of vacant graduate medical education (GME) residency slots with priority given to primary care and general surgery positions and to states with the lowest physician to population ratios. This graduate medical education provision is consistent with ISMS discussions regarding potential workforce shortages, but the provision does not address predicted

physician shortages in non-primary care specialties. Also, the GME funding formula will be changed to promote training in outpatient settings.

Workforce

The bill establishes a National Health Care Workforce Commission to develop a national workforce strategy for recruiting, training and retaining a health care workforce that meets current and projected health care needs.

Prevention and Wellness

ISMS Health Care Reform Principle 7 discusses the need for health care education and prevention and wellness initiatives, and the provisions in the bill are consistent with ISMS policy. The bill establishes a National Prevention, Health Promotion and Public Health Council to develop a national health care strategy. A Prevention and Public Health Fund is created with \$7 billion in funding through 2015 and \$2 billion each year thereafter. A Preventive Services Task Force is created to review scientific evidence related to the effectiveness, appropriateness and cost-effectiveness of clinical preventive services. The bill includes several other prevention and wellness initiatives:

- Medicare beneficiaries will be provided with access to a comprehensive health risk assessment and a personalized prevention plan, and will no longer have to share the costs of certain preventive services recommended by the U.S. Preventive Services Task Force.
- Medicaid will cover tobacco cessation services for pregnant women. Cost sharing will be eliminated for preventive services recommended by the US Preventive Services Task Force and recommended immunizations.
- The federal government will provide employers with technical assistance in evaluating employer-based wellness programs and will conduct a national survey to assess employer-based health policies and programs.
- Employers will be allowed to offer rewards such as premium discounts, cost-sharing waivers or additional benefits up to 30% of the cost of coverage for employees who participate in a wellness program. The government has the authority to increase this reward to 50% of the cost of coverage. By July 2014, the federal government will establish a 10-state demonstration project allowing states to offer rewards for participating in wellness programs to individuals buying insurance in the individual market.
- Chain restaurants and food sold in vending machines must have nutritional information listed.

Fraud and Abuse

The Recovery Audit Contractor (RAC) program is expanded to Medicaid, Medicare Advantage and the Medicare prescription drug benefit program.

The intent requirement for health care fraud is revised to state that a person need not have actual knowledge or specific intent to commit a violation in order to commit health care fraud. Currently that statute applies only to individuals who “knowingly and willfully” offer, pay, solicit or receive remuneration in connection with inducements for referrals.

The bill states that a physician may only certify eligibility for home health services or durable medical equipment if there has been a face-to-face encounter with the patient within six months prior to the certification. The encounter may be performed by a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife or physician assistant.