



**ISMS Analysis of the Patient Protection and Affordable Care Act (HR 3590)  
as Amended by HR 4872 Health Care and Education Affordability Reconciliation Act of 2010**

The following is a summary of HR 3590, the Patient Protection and Affordable Care Act as amended by the reconciliation bill, HR 4872, the Health Care and Education Affordability Reconciliation Act of 2010. At the time of this writing HR 3590 has been signed into law and the Senate and House have passed the reconciliation bill; it is expected to be signed into law. The health reform law 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 fix of the Medicare sustainable growth rate (SGR), are absent from the legislation. Additionally, while the law contains demonstration projects for alternative medical liability reforms, it does not contain comprehensive medical litigation reform. Other items, such as a Medicaid expansion, penalties for not participating in Medicare quality measurement programs and public reporting of quality data, are also of serious concern to ISMS.

## **Physician Payment**

The reform law does not address the 21% Medicare physician pay cut scheduled to take place in 2010. Without a repeal of the SGR, physicians will face payment cuts of 40 % over the next several years.

Medicaid payments are increased to Medicare rates for primary care physicians in 2013 and 2014, with the Federal government covering the cost of the rate increase.

Beginning in 2011 and lasting for five years, primary care physicians would be eligible for a 10% bonus from Medicare on select evaluation and management codes, and general surgeons practicing in health professional shortage areas would be eligible for a Medicare bonus on major procedures. This is new money – these bonuses would not be offset by reductions to other specialty codes.

Minor Medicare payment reductions for services provided in Illinois outside of Chicago and the collar counties will be avoided due to changes in the geographic payment adjustments.

## **Medical Liability Reform**

ISMS has extensive and longstanding policy on the need for medical 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. Beginning in 2011 the Department of Health and Human Services (HHS) can use \$50 million for five-year demonstration grants to states for developing and testing alternatives to the current civil litigation system. Patients can opt out of these alternatives and choose to file a lawsuit. These reforms fall far short of ISMS policies.

### **Antitrust Reform**

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

### **Health Insurance Market Reforms and Health Insurance Exchanges**

The new law 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. Many of the reforms will not go into effect until 2014 but there are several reforms that will be implemented in 2010. These include requiring health plans, including self-insured plans, to cover adult dependents up to age 26, prohibitions on coverage rescissions by insurers, prohibitions on denying coverage to children with pre-existing conditions, elimination of lifetime limits and allowing State insurance authorities to conduct rate reviews.

Within 90 days of enactment, the federal government will establish a temporary national high-risk pool to cover individuals with pre-existing medical conditions. Once the pre-existing conditions limitations are eliminated in 2014, this pool will be dissolved.

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 improvement 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 of 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 longstanding 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 markets 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.

In addition to the exchanges, the new law includes federal start-up funding of \$6 billion to be issued by 2013 to not-for-profit co-ops. The co-ops would be member-run insurance entities and would have to meet the same requirements as private insurance plans in the exchanges related to solvency, licensure, provider payments and network adequacy. The co-ops will have to ensure that any profits made are used to lower premiums, to improve benefits or for other programs intended to improve the quality of health care delivered to its members.

### **Individual and Employer Mandates**

The new law includes an individual mandate with penalties if insurance is not obtained. The penalties for not purchasing health insurance will be phased in. Beginning in 2014, the tax penalty is \$95 but increases to the greater of \$695 per year up to a maximum of three times that amount (\$2,085) per family, or 2.5% of household income by 2016. The penalty will be increased each year by a cost of living adjustment.

Beginning in 2014, 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. The penalty is \$2,000 per full-time worker, but the first 30 workers are exempted from the payment calculation. ISMS does not have policy on an individual mandate, although AMA policy calls for an individual mandate for those above 500% FPL. ISMS has policy opposing employer mandates.

### **Medicaid Expansion**

The law changes Medicaid eligibility to cover low-income individuals below 133% FPL. ISMS policy prefers expanding coverage via subsidies for the purchase of private health insurance, and ISMS has policy in opposition to Medicaid expansion. States will receive 100% federal funding for 2014 through 2016, 95% federal funding for 2017, 94% for 2018, 93% for 2019 and 90% federal funding for 2020 and subsequent years. The federal government will be providing funding for only the additional enrollees resulting from this expansion (rather than all Medicaid enrollees) and the low Illinois Medicaid physician payment rates will still apply, apart from the short-term increase for primary care contained in this legislation (*see p. 1*).

### **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. Tax credits that are inversely related to income are consistent with ISMS Health Care Reform Principle 4.

Employers with fewer 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 and average wages of less than \$20,000. Employers must contribute at least 50% of the premium cost.

### **Taxes**

In 2013, a new Medicare tax of 3.8% will apply to capital gains, dividends, interest and other unearned income for those with incomes above \$200,000 (\$250,000 for couples). Also in 2013, there is an increase in the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%), levied on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly.

A 40% excise tax on high-cost “Cadillac” group health plans with premiums over \$10,200 for individuals and \$27,500 for a family plan will be imposed in 2018 and will then be indexed for inflation. The tax will be applied to the portion of the plan’s cost that exceeds the threshold.

The cost of over-the-counter drugs not prescribed by a physician will no longer be eligible for reimbursement through a health savings account or a flexible spending account. The tax on distributions from a health savings account that are not used for qualified medical expenses is increased from 10% to 20%. In 2013, contributions to a flexible spending account are limited to \$2,500 annually; this limit will be increased in future years by a cost of living adjustment. ISMS has policy supporting favored tax treatment for out-of-pocket health care expenses.

### **Independent Payment Advisory Board**

Beginning in 2015, a new Independent Payment Advisory Board 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’s 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, potentially subjecting physicians to additional payment reductions beyond those imposed by the Medicare sustainable growth rate formula.

### **Physician Quality Reporting Initiative**

A new Medicare physician quality reporting initiative (PQRI) option will be established. Physicians will 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. Also, the PQRI bonuses would be extended until 2014, with a 1% bonus in 2011 and 0.5% bonus in subsequent years. However, the

bonuses would be eliminated in 2015 and 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**

Physicians will be directly affected by several quality improvement provisions, such as public reporting of physician performance on quality measures, 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 *Physician Compare* website will 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, including information on collecting physician quality and efficiency data and on patient experience of care.

The HHS Secretary is directed to provide Medicare claims data to qualified entities for purposes of public provider performance reports. These 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. 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 of data.

Beginning in 2012, Medicare will provide resource use reports to physicians, which compare their resource use with that of other physicians. The reports will be based on an "episode grouper" methodology that combines services into an episode of care and assigns those services to an individual physician.

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 federal government will 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) will 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 or other providers that have at least 5,000 beneficiaries assigned.

Medicare will create an Innovation Center 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 federal government will develop and test alternative bundled payment methodologies through pilot programs designed to improve coordination of care.

### **Physician-Owned Hospitals**

The law prevents construction of new physician-owned hospitals and restricts expansion of existing physician-owned hospitals as of December 2010. There is an exception for hospitals that treat the highest percentage of Medicaid patients in the county. ISMS does not have specific policy on physician-owned hospitals.

### **Comparative Effectiveness Research**

An independent non-profit Patient-Centered Outcomes Research Institute will 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 ensure that its recommendations are not construed as mandates for practice guidelines, coverage recommendations or 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 new law 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 new law 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. The provisions in the new law are consistent with ISMS policy. The law 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 law 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 U.S. 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**

There will be a number of additional measures aimed at reducing waste, fraud and abuse, especially fraudulent billing to Medicare and Medicaid. For example, the Recovery Audit Contractor (RAC) program is expanded to Medicaid, Medicare Advantage and the Medicare prescription drug benefit program. Also, Medicare will require 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.