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CCH BRIEFING *Special Report*

# Senate Finance Committee Approves Health Care Reform Bill

## Highlights

- ✔ Insurance exchanges
- ✔ Insurance market reforms
- ✔ Expanded Medicaid eligibility
- ✔ Promoting primary care
- ✔ Value-based purchasing
- ✔ Medicare payment reforms
- ✔ Program integrity reforms

## Inside



The Senate Finance Committee (SFC) approved, by a 14-9 vote on October 13, an $829 billion health care reform bill. The SFC is the final Congressional committee to tackle health care reform. Four committees (House Ways and Means, House Education and Labor, House Energy and Commerce, and Senate Health, Education, Labor, and Pensions (HELP)) previously reported out different versions of health care reform (America's Affordable Health Choices Act, H.R. 3200).

House and Senate leaders will now try, with strong encouragement from the White House, first to reconcile competing proposals within their own chambers, and then to hammer out a final bill in Conference.

## Employers

**Employer responsibility.** The SFC bill – America's Healthy Future Act – does not mandate employer coverage. But under its "play-or-pay" strategy, employers with more than 50 employees that do not offer coverage would be assessed a fee for each full-time employee (defined as those working 30 or more hours a week) who secures individual coverage. Generally, the maximum fee would be $400 per employee or an amount determined by the U.S. Department of Health and Human Services.

Additionally, employers with 200 or more employees would be required to automatically enroll employees into their health insurance plans. Employees would be able to opt-out of automatic enrollment if they can show other qualifying coverage.

**Small group purchasing.** Small businesses would have access to state-based Small Business Health Options Program (SHOP) exchanges. These exchanges would be web portals that make comparing and purchasing health care coverage easier for small businesses.

**Small business affordability tax credits.** The SFC bill would provide a tax credit to small businesses that contribute at least 50 percent of the cost to the health insurance premiums of their employees. In 2011 and 2012, eligible employers can receive a small business credit for up to 35 percent of their contribution.

Once the exchanges are up and running in 2013, qualified small employers purchasing insurance through the exchange can receive a tax credit for two years that covers up to 50 percent of the employer's contribution. Small businesses with 10 or fewer employees and with average taxable wages of $20,000 or less will be able to claim the full credit amount. The credit phases out for businesses with more than 10 employees and average taxable wages over $20,000, with a complete phaseout at 25 employees or average taxable wages of $40,000.


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## Timetable

It is unclear at this time if the House and Senate will craft a final health care reform bill in conference or if they will pass their different versions between the two chambers until a final bill emerges. Moreover, it is also unclear if health care reform will move under the reconciliation process in the Senate, which requires a mere 51-vote majority rather than a filibuster-proof 60-vote majority to pass.

During the mark up of the SFC bill, many amendments were ruled nongermane because they were not offset. These amendments could be raised again before a final bill comes to a vote. A final vote is not anticipated until late November or early December. No single effective date has been set for all health care reform provisions. While many of the "play-or-pay" provisions will not go into full effect until 2013, long transition rules and grandfather provisions exist. Some details will likely be fleshed out by regulations issued in 2010 and 2011.

**Tax on high-cost insurance.** The SFC bill would impose a 40 percent nonrefundable excise tax on group insurers if the aggregate value of employer-provided health coverage exceeds $8,000 for individual coverage and $21,000 for family coverage. Designed principally to limit use of so-called "Cadillac plans," the excise tax for these high-end policies would be imposed pro-rata on issuers.

For self-insured plans, the plan administrator (including employers that act as plan administrators) would pay the excise tax. Transition relief would be available for coverage in high-cost states. The excise tax would take effect until 2013.

**Impact:** *Some taxpayers would be insulated from the excise tax. Under the SFC bill, the thresholds would be $9,850 for single coverage and $26,000 for family coverage for high-risk jobs such as law enforcement personnel, fire fighters and other first responders, as well as individuals in high risk occupations, such as mining. Retired individuals age 55 and older also would be eligible for the higher thresholds.*

**Comment:** *The SFC bill also would exclude fixed indemnity health plans purchased with after-tax dollars from the excise tax. These are employee-paid plans that pay a fixed dollar amount for certain medical procedures and/or hospitalization.*

**Flexible spending arrangements.** In imposing its excise tax on high-cost plans that exceed a certain dollar amount ($8,000 for individual coverage and $21,000 for family coverage), the SFC bill would count an employee's contribution to a health care flexible spending arrangement (FSA) toward the overall dollar limit.

In addition, the SFC bill would prohibit taxpayers from using health FSA dollars to pay for over-the-counter medications (unless prescribed by a health professional). The bill also would cap annual contributions to a health FSA at $2,500.

**Comment:** *Currently, there is no statutory or regulatory maximum on health FSA contributions.*

**Health savings accounts.** Generally, individuals under age 65 must pay an additional tax if distributions from a health savings account (HSA) are not used for qualified medical expenses.

The SFC bill would increase the additional tax from 10 to 20 percent.

**Cafeteria plans.** Small employers would be able to provide tax-free benefits to their employees through a new vehicle called a Simple Cafeteria Plan. The bill would provide for a safe harbor from the nondiscrimination requirements for cafeteria plans for eligible small employers.

**Comment:** *The safe harbor would require that the cafeteria plan satisfy minimum eligibility and participation requirements and minimum flex-credit contribution requirements.*

**Retiree prescription drug subsidy.** The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created a retiree drug subsidy program to encourage employers to provide prescription drug coverage to their retirees. Employers receive a tax-favored subsidy. The subsidy, which is excluded from an employer's income, is equal to 28 percent of the allowable costs, including administrative costs, attributable to covered prescription drug costs incurred by a qualifying retiree of between $295 and $6,000 in 2009. The SFC bill would eliminate the exclusion.

**Reporting and disclosure.** The SFC bill would require employers to disclose the value of employer-provided health insurance to employees on their annual

Forms W-2. The disclosure requirement has been proposed to start for tax years beginning after December 31, 2009.

## Individuals

**Health insurance exchanges.** The SFC bill would create state-based web portals, or health insurance exchanges, that would direct consumers seeking to purchase coverage in the individual market to all the health plan options available in their zip code.

**Individual responsibility mandate.** Under the SFC proposal, individuals without qualifying coverage would pay an annual nonrefundable excise tax. Depending on income, the excise tax would start at $200 per year for individuals in 2014 and climb to $750 per year for individuals by 2017.

Comment: *Exemptions from the requirement to have health coverage would be allowed for religious objections (as defined in Medicare) and undocumented individuals.*

**Affordability credits.** Tax credits for low- and middle-income individuals would be available to subsidize the purchase of health insurance. Beginning in July 2013, tax credits would be available on a sliding scale for individuals and families between 134—400 percent of the Federal Poverty Level to help offset the cost of private health insurance premiums.

## Market Reforms

Beginning in 2013, insurance companies would be required to issue health insurance coverage to all individuals regardless of health status. Insurers would be prohibited from limiting coverage based on pre-existing conditions.

Limited variation in premium rates would be permitted for tobacco use (no more than 1.5:1), age (no more than 4:1), and family composition (no more than 3:1 for a family). Variation in rating would be allowed between geographic areas, but would not differ within a geographic area. Total variation in premiums would be limited to 6:1.

Comment: *These rating rules for the individual market also would apply to the small group market, as defined by the states.*

**Options for standard benefits.** The SFC bill creates four benefit categories for the reformed health insurance market: bronze, silver, gold and platinum. No policies (except grandfathered policies) would be issued in the individual or small-group markets that do not comply with one of the four categories.

All plans would be required to provide:

- primary care and first-dollar coverage for preventive services,
- emergency services,
- medical and surgical care,
- physician services,
- hospitalization,
- outpatient services
- day surgery and related anesthesia,
- diagnostic imaging and screenings,
- maternity and newborn care,
- pediatric services,
- prescription drugs,
- radiation and chemotherapy, and
- mental and behavioral health and substance abuse services.

**Executive compensation limitations.** The SFC bill contains a provision that would limit the deductibility of executive compensation for insurance providers if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements in the bill ("covered health insurance provider"). The deduction is limited to $500,000 per taxable year and applies to all officers, employees, directors, and other workers or service providers performing services, for or on behalf of, a covered health insurance provider.

# Medicare and Medicaid

The Medicare and Medicaid changes in this legislation reflect two goals – increasing health care quality through the setting of measurable standards as well as financial incentives; and shifting the focus of care in these two programs to primary and preventive care.

## Medicaid Coverage

**Medicaid eligibility.** The SFC bill would create a new Medicaid eligibility category for all non-elderly non-pregnant individuals otherwise ineligible for Medicaid. Starting in 2011, the new mandatory minimum Medicaid income eligibility level for all non-elderly individuals would be 133 percent of the federal poverty level (FPL). In 2013, when the state-based insurance exchanges and requirement that most individuals purchase health insur-

ance goes into effect, individuals at or below 133 percent of FPL would not be subject to the individual mandate to purchase insurance. In 2014, income eligibility for Medicaid would be based on modified gross income; state laws that disregard certain types of income for income eligibility purposes would no longer apply.

Individuals newly eligible for Medicaid would receive a benchmark benefit package that meets minimum creditable coverage requirements.

Beginning in 2014, individuals with income below 100 percent of FPL would be eligible for Medicaid but would not be eligible for tax credits to participate in the state insurance exchanges. Non-elderly, non-pregnant adults between 100 and 133 of FPL would be able to choose between Medicaid and coverage through a state exchange.

**Comment:** *Under current law, the mandatory minimum Medicaid income level has ranged from 11 percent to 68 percent of FPL, although in some states parents with incomes of up to 200 percent of FPL have been made eligible for Medicaid through state plan amendments.*

**Medicaid program payments.** The Federal Medical Assistance Percentage (FMAP) would still be used to determine federal Medicaid payments to states. Starting in 2014, however, additional federal financial assistance will be available to defray the costs of covering newly eligible Medicaid recipients. States that currently offer minimal or no coverage of the newly eligible population would receive more assistance initially than states that currently offer coverage to at least some of the non-elderly, non-pregnant population.

**Comment:** *Under current law, FMAP has a statutory minimum of 50 percent and a maximum of 83 percent. Under the SFC change, the FMAP maximum would increase to 95 percent.*

**Medicaid and employer-sponsored insurance.** Effective July 1, 2013, states would be required to offer premium assistance to Medicaid beneficiaries who are offered employer-sponsored insurance. States also would be required to provide Medicaid-covered services that are not offered under the private plan.

**Treatment of the territories.** The five U.S. territories that offer Medicaid benefits operate their programs under different rules than the states. Medicaid programs in the territories are subject to annual federal spending caps. The SFC bill would increase these spending caps by 30 percent and increase FMAP to the territories to 55 percent beginning on January 1, 2011.

**Medicaid Improvement Fund.** The bill would rescind funds appropriated for the Medicaid Improvement Fund in fiscal years 2014 through 2018, a total of $700 million.

**Children's Health Insurance Program (CHIP).** The SFC bill would maintain the existing CHIP structure and income eligibility rules. CHIP-eligible children who cannot enroll in CHIP because of federal allotment caps would be eligible for credits in the state insurance exchanges.

**Enrollment coordination with the state exchange.** States would be required to establish a Medicaid enrollment website to enable Medicaid-eligible individuals to apply for tax credits through the state insurance exchanges. HHS would be required to provide guidance to states regarding standards and best practices for enrolling vulnerable populations, such as children, homeless youth, children with special needs, pregnant women, minorities, and victims of abuse, in Medicaid and CHIP.

**Comment:** *States will be encouraged to use a single streamlined form for applications relating to Medicaid, CHIP, and tax credits for the state insurance exchange.*

**Presumptive eligibility.** Hospitals that participate in Medicaid would be added to the list of providers who may make presumptive eligibility decisions for Medicaid enrollment. Using presumptive eligibility, providers may enroll certain individuals into Medicaid for a limited period of time before their full Medicaid applications are filed and processed, based on a preliminary determination of likely Medicaid eligibility.

**Comment:** *Presumptive eligibility generally is used to facilitate the beginning of treatment for children, pregnant women, and women with cervical and breast cancer.*

**Long-term care services.** The Aging and Disability Resource Center would be allocated $10 million each year for five years, starting in fiscal year 2010, to help streamline information about and access to long-term care services. The bill also would establish the Community First Choice Option to help states establish programs to provide home– and community-based care for individuals who otherwise would be institutionalized. In addition, the bill would extend the Money Follows the Person Rebalancing Demonstration program through the end of FY 2015. This demonstration program is another way for states to encourage home- and community-based care over institutional care.

**Other Medicaid services.** Free-standing birthing centers would be identified as Medicaid providers. Children would be eligible for hospice services without giving up other Medicaid-eligible services. The definition of "categorically needy" eligibility group would be expanded to include non-pregnant individuals who would be eligible for family planning services. Under current law, states can provide family planning services only after receiving a waiver to do so.

Comment: *The Senate bill amends the definition of "medical assistance" to include both payment for services provided and the services themselves.*

**Repayment of Medicaid overpayments.** The bill would extend the 60 days that states currently have to repay the federal share of a Medicaid overpayment to one year.

**Medicaid prescription drugs.** When the Senate Finance Committee bill was first released, it included a provision to make prescription drugs a mandatory benefit under Medicaid. This provision was not included in the version approved by the committee. However, smoking cessation drugs, barbiturates, and benzodiazepines would be removed from Medicaid's excluded drug list under the bill.

The flat rebate percentage used to calculate Medicaid's basic rebate for outpatient brand name prescription drugs would be increased from 15.1 percent to 23.1 percent for drugs other than certain clotting factors and certain pediatric drugs. The rebate for generic drugs would increase from 11 percent to 13 percent of the average manufacturer's price (AMP). Medicaid managed care organizations would be able to negotiate with drug manufacturers for higher rebates. The federal upper payment limit (FUL) for multiple source drugs would decrease to no lower than 175 percent of weighted average of the most recent AMP for equivalent multiple source drugs available nationally through pharmacies.

**Medicaid disproportionate share payments.** Existing state disproportionate share hospital payments would stay the same until the state's uninsured rate decreases by at least 50 percent, at which point state DSH allotments would be cut by 50 percent.

Comment: *DSH payments are extra payments to hospitals that serve a disproportionate share of low-income individuals and Medicaid beneficiaries. After this reform plan is implemented, fewer people will be uninsured, so hospitals will be seeing more patients who have insurance, decreasing the need for DSH payments.*

**Dual eligibles.** A Federal Coordinated Health Care Office would be established within CMS to improve the coordination of benefits for individuals who are eligible for both Medicare and Medicaid – "dual eligibles."

Comment: *Dual eligibles make up only 20 percentage of the Medicare and Medicaid population; however, they account for 46 percent of Medicaid expenditures and 25 percent of Medicare expenditures.*

**Medicaid quality.** Effective July 1, 2011, federal payments to states would be prohibited for Medicaid services related to health care acquired conditions. HHS also would be charged with developing a set of health care quality measures specific to adults who are eligible for Medicaid.

Comment: *The definition of health care acquired conditions under Medicaid would be similar to the existing definition of hospital-acquired conditions under Medicare, but the Medicaid definition would not be limited to conditions acquired in hospitals.*

**Medicaid demonstrations.** The bill would establish a bundled payment demonstration in up to eight states. Under the demonstration, a unit of payment for acute care provided in a hospital would be expanded to include post-acute care in both hospital and non-hospital settings, as well as physician services.

A Medicaid Global Payments demonstration will be established in up to five states. Under this demonstration, a safety net hospital participating in Medicaid would be permitted to change from a fee-for-service payment structure to a capitated, global payment structure.

Another demonstration project would allow pediatric medical providers to organize as accountable care organizations.

Comment: *The idea behind both of these demonstrations is to improve the continuity of care for patients as they move from an acute care setting to a home or other facility, to reduce the likelihood that they will be readmitted to the hospital to treat the same condition.*

**American Indians and Alaska Natives.** Cost-sharing would be prohibited under Medicaid for all American Indians and Alaska Natives with incomes at or below 300 percent of FPL. Indian tribes, tribal organizations, and urban Indian organizations would be the payers of last resort (usually, Medicaid is the payer of last resort).

Tribes also would be allowed to accept applications for the new state-based insurance exchanges.

**Health disparities.** Uniform categories would be established for collecting data on Medicaid-related survey and administrative forms relating to race and ethnicity, sex, and primary language. In addition, CMS would be required to collect data from providers relating to individuals with disabilities. Federally funded population surveys would be required to collect sufficient data on racial and ethnic subgroups to generate statistically reliable results in studies comparing health disparities populations.

## Promoting Disease Prevention and Wellness

**Medicare.** Beginning in 2011, Medicare beneficiaries would have access to a comprehensive health risk assessment that would identify chronic diseases, modifiable risk factors, and emergency or urgent health needs. Medicare will pay for a personalized prevention plan. Beneficiaries will be eligible for one wellness visit every year. Beneficiaries will not be subject to cost sharing for certain preventive services. The bill would provide $100 million over five years for a program of incentives to beneficiaries who successfully participate in healthy lifestyle programs.

Comment: *A report cited by the Senate Finance Committee noted that elderly patients are price-sensitive and that a $10 co-payment increase led to a 20 percent decline in physician office visits.*

**Medicaid.** States that provide Medicaid coverage for all federally approved preventive health services and immunizations, without cost sharing, would receive a one percentage point increase in their FMAP payments. HHS would be required to develop criteria for healthy lifestyle programs that are uniquely suited to address the needs of Medicaid-eligible beneficiaries.

**Medicaid health home.** A new state plan option would allow Medicaid enrollees with at least two chronic conditions; or with one chronic condition and at risk of developing a second one; or with at least serious and persistent mental health condition; to designate a provider as their "health home."

**Primary care/general surgery bonus.** Select evaluation & management codes under the Medicare physician fee schedule would receive a 10 percent bonus for five years, beginning January 1, 2011. The groups of codes to which this bonus would apply would be office visits, home visits, nursing facility visits, and domiciliary, rest home, or custodial care services. Fifty percent of the cost of the bonuses would be offset through an across-the-board reduction to all other codes, except for physicians who primarily provide services in a health professional shortage area.

**Redistribution of GME slots.** HHS would establish a policy to redistribute 80 percent of currently unused residency training slots as a way to encourage increased training, particularly in the areas of primary care and general surgery.

**Residency training programs.** Effective for cost reporting periods beginning on or after July 1, 2010, all time spent by a resident would count toward Medicare direct graduate education payment, without regard to the setting where the activities are performed, if the hospital continues to incur the costs of the stipends and the fringe benefits of the resident during the time the resident spends in the setting. When calculating GME payments, Medicare would count the time that residents in approved training programs spend in certain non-patient care activities in a nonhospital setting that is primarily engaged in furnishing patient care.

Comment: *This change is designed to promote training in outpatient settings and to ensure the availability of residency programs in rural and underserved areas.*

**Resident cap positions from closed hospitals.** HHS would promulgate regulations to establish a process where the residency allotments in a hospital with an approved medical residency program that closes could be used to increase the otherwise applicable residency limit for other hospitals. A specific priority order would be established to redistribute these residency positions.

**National workforce strategy.** HHS would establish a Workforce Advisory Committee to create a strategy for recruiting, training, and retaining a health workforce that meets existing and future health care needs. HHS would establish demonstration grants for programs to train low-income individuals for specific health care occupations where labor shortages are expected, such as personal and home care aides.

Qualified teaching health centers—community based, ambulatory patient care centers with a primary care residency program—would be eligible for payments for direct graduate medical education expenses and other indirect expenses. A graduate nurse education demonstration program would be established for the training of advance practice nurses in hospital settings.

## Value-based Purchasing

**Hospitals.** The SFC bill would expand on the existing hospital value-based purchasing program (VBP) within Medicare, moving beyond pay-for-reporting and instead paying hospitals based on actual performance. Beginning in FY 2012, inpatient prospective payment system (IPPS) hospitals would receive incentive payments based on meeting quality performance standards. The new VBP program would be based on quality measures that are currently reported by hospitals in the areas of heart attack, heart failure, pneumonia, surgical care, and patient perception of care.

Funding for value-based incentive payments would be generated by reducing Medicare IPPS payments to hospitals.

**Physicians.** The existing Physician Quality Reporting Initiative would be expanded to provide incentive payments to eligible professionals who voluntarily complete a specific certification and practice assessment. Eligible professionals who do not participate in the PQRI program face payment reductions starting in 2013. CMS would be required to provide timely feedback to physicians based on their participation in the PQRI program. The agency also would establish an appeals process for providers who participate in the program but don't quality for incentive payments.

**Inpatient rehabilitation facilities, long-term care hospitals and hospices.** HHS would establish new quality reporting programs for inpatient rehabilitation facilities, long-term care hospitals, and hospices. Quality measures would be selected by FY 2013 and these providers would be required to participate in FY 2014, or face a market basket reduction of 2 percent.

**Cancer hospitals.** HHS would establish new quality reporting programs for cancer hospitals. Quality measures would be selected by FY 2013; mandatory quality measure reporting would start in FY 2014. IPPS-exempt cancer hospitals would be required to report these quality measures as part of their Medicare provider agreements.

**Home health and skilled nursing facilities.** HHS would be required to complete and submit to Congress a Medicare value-based purchasing implementation plan for home health agencies by FY 2011, and for skilled nursing facilities by FY 2012.

## Other Quality Initiatives

**Hospital acquired conditions.** The legislation would apply a new payment adjustment to hospitals ranked in the top quartile of national, risk-adjusted hospital acquired condition (HAC) rates. Starting with FY 2015, hospitals in the top quartile of national HAC rates would receive 99 percent of their Medicare payments.

**Quality infrastructure.** HHS would be directed to establish a national quality improvement strategy that includes processes to improve the delivery of health care services, patient health outcomes, and population health. The President would convene a working group of federal departments and agencies to collaborate on a national quality improvement strategy.

**Accountable care organizations (ACOs).** Groups of providers who voluntarily meet certain statutory criteria, including quality measurements, would be recognized as ACOs and be eligible to share in the cost-savings they achieve for the Medicare program. Qualified ACOs would have to meet specified criteria; ACOs would earn incentive payments by meeting specific quality thresholds. CMS would assign Medicare fee-for-service beneficiaries to ACOs based on their use of Medicare items and services in preceding periods.

**Comment:** *The following groups of providers and suppliers would be eligible for participation: practitioners in group practice arrangements; networks of practices; partnerships or joint-venture arrangements between hospitals and practitioners; hospitals employing practitioners. Practitioners would be defined as physicians, regardless of specialty, nurse practitioners, physician assistants, and clinical nurse specialists.*

**CMS Innovation Center.** The Innovation Center will be a new office established within CMS that is authorized to test, evaluate, and expand different payment structures and methodologies aimed at fostering patient-centered care, improving quality, and slowing the rate of Medicare cost growth.

**Pilot program on payment bundling.** HHS would be required to develop, test and evaluate alternative payment methodologies through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting in 2013. The pilot program's bundled payment would be made to a Medicare provider or other entity comprised of multiple providers to cover the costs of acute care inpatient and outpatient hospital services, physician services and post-acute care.

**Reducing avoidable hospital readmissions.** CMS would calculate national and hospital-specific data on readmission rates for eight specific conditions. Starting

in FY 2013, hospitals with readmission rates above a certain threshold would have payments for the original hospitalization reduced by 20 percent if a patient with a selected condition is re-hospitalized with a preventable readmission within seven days and by 10 percent if the re-hospitalization happens within 15 days.

**Gainsharing demonstration.** The existing gainsharing program under which hospitals and physicians can share in the savings achieved based on quality and efficiency of care improvements would be extended until Sept. 30, 2011.

**Home-based chronic care management program.** The legislation creates a chronic care coordination pilot project to provide primary care services to the highest cost Medicare beneficiaries with multiple chronic conditions in their home. Interdisciplinary teams of health care professionals caring for patients with multiple chronic conditions in their homes would be eligible for shared-savings if they achieve quality outcomes, patient satisfaction and cost savings.

## Part A Payments

**Home health rebasing.** Starting in CY2013, HHS would be directed to rebase home health (HH) payments to reflect the number and mix of HH services, level of intensity of services, and the average cost of providing care. The new reimbursement system would be phased in from 2013 through 2016.

**DSH reforms.** Starting no later than 2015 and continuing on an annual basis, the Secretary would make disproportionate share payments equal to 25 percent of the disproportionate share payments that would otherwise be made.

**Hospital wage index.** By December 31, 2011, HHS would be required to provide a plan to Congress on how to comprehensively reform the Medicare wage index system, based on goals set forth in the Medicare Payment Advisory Commission (MedPAC) June 2007 report. HHS also would be required to restore the ratios used in determining geographic hospital wage index reclassification to pre-October 1, 2008 levels until the first fiscal year one year after the Secretary submits the wage index reform plan to Congress.

**Market basket cuts.** Annual market basket updates for 2010 would be reduced for home health and hospice providers; inpatient and outpatient hospitals; inpatient psychiatric facilities; and inpatient rehabilitation and long-term care hospitals. In addition annual updates based on either market basket indices or the Consumer Price Index would be reduced to reflect increases in provider productivity.

**Medicare Commission.** The legislation would establish an independent Medicare Commission that would develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing Medicare cost-growth, and improving the quality of care delivered to Medicare beneficiaries. The Commission would be tasked with presenting proposals to Congress that would reduce Medicare spending by targeted amounts compared to the trajectory of Medicare spending under current law.

**FLEX grant program.** The Medicare Rural Hospital Flexibility Program would be extended for two years until 2012.The proposed change will allow grant money to be used to help small rural hospitals participate in other delivery system reforms included in this legislation, such as value-based purchasing programs and accountable care organizations.

**Hold harmless payments.** In 2010 and 2011, small rural hospitals and sole community hospitals would receive 85 percent of the payment difference between payments made under the outpatient hospital prospective payment system and the prior reimbursement system.

**Medicare dependent hospital program.** This program, which provides extra payments under IPPS for small rural hospitals with a high proportion of Medicare patients, and which is set to expire Sept. 30, 2011, would be extended until Sept. 31, 2013. HHS would be required to conduct a study on the need for an additional Medicare inpatient payment for urban Medicare-dependent hospitals paid under PPS which receive no additional payments or adjustments under PPS.

**Low-volume hospitals.** A temporary adjustment that would increase payment in FY2011 and 2012 for certain low-volume hospitals would be created.

**Critical access hospitals.** CAHs would be eligible to receive 101 percent of reasonable costs for providing outpatient services regardless of billing method and for providing qualifying ambulance services.

**Rural ambulance payments.** The legislation would extend until January 1, 2012, the bonus payments under Medicare to ambulance service providers which serve the most rural quartile of counties ("super rural") areas.

## Medicare Part B

**Sustainable growth rate.** The annual update to the conversion factor used in the determination of the Medicare fee schedule would be a 0.5 percent increase in 2010.

**Comment:** *The sustainable growth rate formula, if left unadjusted, would lead to a 21 percent reduction in Medicare physician payments beginning January 1, 2010. This is a one-year fix to the problem – physicians would still face a significant pay cut in 2011 under existing law.*

**Medicare work geographic adjustment.** The 1.00 floor for the geographic index for physician work for an additional two years through December, 2012.

**Misvalued relative value units.** HHS would be required to periodically identify physician services as being potentially misvalued, and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule.

**Therapy caps.** The process for determining exceptions to outpatient therapy service caps would be extended for two years, through December 31, 2011.

**Extension of specific services.** The legislation would extend the following provisions: (1) direct payment to independent laboratories for the technical component of certain pathology services (until January 1, 2012); (2) increased payments for Medicare ambulance services (until January 1, 2012); (3) three-year moratorium on the establishment of new long-term care hospitals (for two years); (4) increased payments for certain Medicare mental health services (until January 1, 2012).

**Part B premiums.** The current income thresholds used to determine Medicare Part B premiums will be frozen from 2011 through 2019.

**Comment:** *The Part B premium is set at 25 percent of the program's costs per enrollee. However, higher income beneficiaries pay a premium based on a higher percentage per enrollee costs. For 2009, the existing income thresholds for individuals and the accompanying share were as follows: $85,000 (35 percent); $107,000 (50 percent); $160,000 (65 percent); $213,000 (85 percent). The income thresholds will increase for 2010 based on changes in the consumer price index.*

## Medicare Part C

**Payments.** The Chairman's Mark would base the calculation of Medicare Advantage (MA) benchmarks on actual plan costs as reflected in plan bids rather than statutorily set rates.

**Comment:** *Using plan bids to set MA benchmarks would encourage plans to compete more directly on the basis of price and quality rather than on the level of extra benefits offered to enrollees. Further, since plan bids are usually lower than the benchmark rates, this change would provide cost savings to the Medicare program.*

**MA beneficiary protection.** Beginning in 2011, MA plans would be prohibited from charging cost sharing that is greater than the cost sharing under the original Medicare program for certain services for which beneficiaries need the highest level of predictability and transparency, such as chemotherapy treatment, renal dialysis and skilled nursing care. The legislation also would modify how MA plans can use rebates and bonuses for providing additional benefits to enrollees.

Sponsors of prescription drug plans and Medicare Advantage prescription drug plans would be required to develop a uniform exceptions and appeals process by 2012.

The annual enrollment period dates for Medicare Advantage and Part D would shift to the period October 15 to December 7, beginning in 2011. The annual open enrollment period (January 1 through March 31) would be eliminated for MA plans. Also beginning in 2011, beneficiaries who enroll in Medicare Advantage or prescription drug plans during the annual enrollment period could disenroll and return to traditional fee-for-service during a 45-day period (January 1 – February 15).

**Special needs plans.** The SNPs coordinated care plan, which allowed plans to enroll individuals who are institutionalized; dually eligibly; and severely disabled, was authorized through Dec. 31, 2010. The legislation would extend SNP authority through Dec. 31, 2013.

## Medicare Part D

**"Donut hole" coverage.** The legislation would establish a discount program for beneficiaries who enroll in Part D and have drug spending that falls into the coverage gap, or "donut hole." Manufacturer discounts on brand-name drugs that are covered under Part D and are on plan formularies would be provided. The discount would be available during the entire coverage gap—that is, at the point when total prescription costs of a beneficiary exceeds the initial coverage limit ($2,700 in 2009) and reaches the catastrophic coverage limit ($6,153 in 2009) each year.

**Comment:** *The donut hole was put in place when Medicare Part D was created in 2003. Its purpose was political, not practical. Congress had to make the legislation that enacted Medicare Part D budget neutral and requiring a large "gap" in prescription drug coverage, where the government paid nothing and the beneficiary*

*shouldered the entire cost of prescription drugs, was one of the ways that the legislation could pass scrutiny by the Congressional Budget Office.*

**Part D premium subsidies.** The legislation makes a number of refinements in the determination of the low-income subsidy that is provided to certain qualifying beneficiaries under Part D. In addition, beginning in 2011, the legislation would reduce the premium subsidy amount for beneficiaries who modified adjusted gross income exceeds the thresholds used under Part B (in 2009, $85,000 for an individual and $170,000 for a couple).

**Part D drug formularies.** Part D sponsors would be prohibited from removing a covered drug from a plan formulary; restrict or limit coverage of a drug; or increase cost sharing from a drug, other than on the date on which Part D sponsors may begin marketing their plans for the following plan year.

## Miscellaneous Medicare Provisions

**Federally qualified health centers (FQHC).** HHS would be directed to establish a prospective payment system for Medicare-covered services provided by FQHCs. The PPS payment rate would be extended to health plans and health insurers participating in the new state insurance exchanges.

**TRICARE beneficiaries.** A 12-month special enrollment period for Medicare Part B would be created for military retirees and their families who are otherwise eligible for TRICARE and entitled to Part A, but who have declined Medicare Part B.

**Patient-centered outcomes research.** The legislation would authorize the establishment of a private, nonprofit corporation that would be known as the Patient-Centered Outcomes Research Institute. The purpose of the Institute would be to assist patients, clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence through research and evidence synthesis. The research would focus on the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed, and would consider variations in patient subpopulations.

## Program Integrity

**Physician referral to hospitals.** Beginning no later than 18 months after the date of enactment, only hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals that have physician ownership and a provider agreement in operation on November 1, 2009, and that met other specified requirements would be exempt from this self-referral ban. These requirements would address conflict of interest, bona fide investments, and patient safety.

**Physician transparency.** The legislation calls for transparency in the relationship between physicians and applicable manufacturers with respect to payments and other transfers of value and physician ownership or investment interests in manufacturers. It calls for annual transparency reports, penalties for noncompliance, procedures for the submission of information and public availability of this information.

**Nursing home transparency.** The legislation would make a number of changes aimed at improving transparency of information about skilled nursing facilities and nursing homes, in particular concerning required disclosure of ownership; accountability requirements; the Nursing Home compare website; reporting of expenditures; standardized complaint form; ensuring staffing accountability; civil money penalties; dementia and abuse prevention training; and nursing home background checks.

**Provider screening.** All providers and suppliers would have to be screened before being granted Medicare billing privileges. At a minimum, this screening would require licensure checks.

**Provider compliance.** All Medicare and Medicaid providers and suppliers would be required to implement compliance programs as a condition of participation. Intermediate sanctions and program safeguards would be established to provide greater flexibility to CMS and law enforcement to address problems. The maximum period for submission of Medicare claims would be reduced to not more than 12 months. The 60 days providers and suppliers have to repay Medicare overpayments would be modified to either 60 days after the date on which the overpayment was made or the date the corresponding cost report is due. The civil monetary penalty (CMP) law would be amended in several instances to increase penalties and extend use of CMPs.

**HIPAA transactions.** The legislation would establish a timeline for accelerating the development, adoption and implementation of a set of operating rules for each HIPAA transaction for which there is an existing standard. Electronic funds transfer (EFT) of health claims payments would be added as a HIPAA transaction and provide for the adoption and enforcement of a standard for EFT.

**Recovery Audit Contractors.** The Recovery Audit Contractor (RAC) program would be extended to Medicare Parts C and D as well as to Medicaid.