APPENDIX A

AMERICA'S HEALTHY FUTURES ACT OF 2009
U.S. SENATE FINANCE COMMITTEE
MODIFIED CHAIRMAN'S MARK

I. INSURANCE COVERAGE PROVISIONS

Insurance Market Reforms

The Senate Finance Committee bill (also known as the Chairman's Mark) would establish new federal rules for the individual market, including requiring all insurance carriers to accept every individual who applied for coverage (guaranteed issue), and would not allow rating on the basis of health status. Premiums could reflect age (with a maximum rate variance between age bands of 4:1), tobacco use, family composition, and geography. Carriers that rate on tobacco use would be required to cover tobacco-cessation programs. Insurers would be prohibited from rescinding coverage and would be required to report the proportion of premiums spent on items other than medical care beginning in 2010. The bill would allow states to phase-in the same rating rules for the small group market over a five-year period. States would have the option to merge the pooling and rating requirements of the individual and small group markets.

Health Insurance Exchange

The Senate Finance Committee bill would require states, with technical assistance from the secretary of health and human services (HHS) to establish an exchange for the individual market and a separate small business health options program exchange for the small-group market. This could be a single exchange with separate resources for individuals and small employers. Groups of states could form regional exchanges. After three years, states could permit other entities to operate an exchange subject to approval by the secretary. All insurance carriers in the individual and small-group markets that are licensed by a state would be required to offer a plan through the exchanges. But the individual and small-group markets would not be replaced by the exchange. In 2015, states would have the opportunity to opt out of the federal requirements through a waiver,

if they were able to demonstrate that they could offer all residents coverage at least as comprehensive as required by the bill.

Who Is Eligible to Participate?

The Senate Finance Committee bill allows individuals and employers with fewer than 50 employees—or 100 employees in a state option—to purchase coverage through the exchange. Beginning in 2015, states must allow small businesses with up to 100 employees to purchase coverage through the small-business health options program exchange and states may allow employers with more than 100 employees into the state exchange beginning in 2017.

An amendment to the bill would require members of Congress and congressional employees, beginning July 1, 2013, to use their employer contribution (adjusted for age rating) to purchase coverage through a state-based exchange, rather than using the traditional Federal Employees Health Benefits Program.

After an initial open enrollment period between March and May 2013, open enrollment in the individual market would occur between October 15 and November 30, 2013. Special enrollment periods would be allowed for qualifying events such as becoming a dependent through marriage or birth or the loss of health insurance coverage.

Standard Benefits Package

The Senate Finance Committee bill would establish four benefit categories—bronze, silver, gold, platinum. No policies could be sold in the small-group and individual market that did not meet the actuarial standards for the benefit categories established by law. All carriers selling in the individual and small group markets would be at least required to offer silver and gold plans.

The bill would define an essential health benefits package that would include: preventive and primary care, emergency services, hospitalization, physician services, outpatient services, day surgery and related anesthesia, diagnostic imaging and screenings (including x-rays), maternity and newborn care, pediatric services (including dental and vision), medical/surgical care, prescription drugs, radiation and chemotherapy, and mental health and substance abuse services that at least meet minimum standards set by federal and state laws. In addition, plans could charge no cost-sharing (e.g., deductibles, copayments) for preventive care services, except in cases where value-based insurance design is used. Plans could not include lifetime limits on coverage or annual limits on any

benefits. Any insurer that rates on tobacco use must also provide coverage for comprehensive tobacco-cessation programs including counseling and pharmacotherapy (prescription and non-prescription).

The bronze package would represent minimum creditable coverage with an actuarial value of 65 percent (i.e., covering 65 percent of claims costs) with out-of-pocket spending limited to that which is defined for health savings accounts (HSA) or $5,950 for individual policies and $11,200 for family policies. The silver benefit package would have an actuarial value of 70 percent and the same out-of-pocket limits; the gold package would have an actuarial value of 80 percent and the same out-of-pocket limits, and the platinum would cover 90 percent of costs with the same out-of-pocket limits. A catastrophic benefit package could be made available for young adults ages 25 or younger, similar to HSA-eligible, high-deductible plans, with preventive services excluded from the deductible as under current HSA law. People who could not find a plan with a premium that is 8 percent or less of their income would be able to purchase the young adult plan, as well.

Stand-alone pediatric dental plans could be sold through the exchange but would have to comply with the consumer protections.

Plans sold in the exchanges would be required to apply parity in cost-sharing for treatment of conditions in 1) inpatient hospitals, 2) outpatient hospitals, 3) physician services, and 4) other services, except where value-based insurance design is used. Each plan would also be required to meet the class and category of drug coverage requirements in Medicare Part D (generally Part D plans must offer two drugs in each class or category).

Insurers participating in the state exchanges would be required to charge the same premium for the same products sold in the service area defined by the state regardless of whether the plan is purchased inside or outside the exchange.

Sliding-Scale Premium and Cost-Sharing Subsidies

The Senate Finance Committee bill would provide refundable, advanceable, sliding-scale tax credits for health plans purchased through the exchange. People with employer-based coverage would not be eligible for the credits unless the actuarial value of their plan was less than 65 percent (i.e., the bronze plan offered through the exchange) or their premium contribution exceeded 10 percent of income. Credits would be available beginning in

2013 for individuals and families earning between 134 percent and 400 percent of the federal poverty level. Beginning in 2014, credits would be available for those earning between 100 percent and 133 percent of the poverty level, based on the second-lowest-cost silver plan in the area where the individual resides. Premium contributions would be no greater than 2 percent of income for those earning 100 percent of poverty, and would range upward to 12 percent of income for those at 300 to 400 percent of poverty.

Cost-sharing for families with lower incomes would be limited. Cost-sharing subsidies would limit cost-sharing such that the actuarial value of essential benefit packages for families earning between 100 percent and 150 percent of poverty would be increased to 90 percent. For those earning between 150 percent and 200 percent of poverty the subsidies would increase actuarial value of the plan to 80 percent.

In addition, out-of-pocket expenses would be capped for families earning between 100 percent and 200 percent of poverty at one-third of the HSA limit or $1,964 for individuals and $3,937 for families. For families earning between 200 percent and 300 percent of poverty, out-of-pocket expenses would be capped at one-half of the HSA limit or $2,975 for individuals and $5,950 for families. For those with incomes between 300 percent and 400 percent of poverty, within the same actuarial value, out-of-pocket expenses would be capped at two-thirds of the HSA limit or $3,927 for individuals and $7,392 for families. Cost-sharing is eliminated for preventive services.

The premium and cost-sharing subsidies would be determined through the application process at a state exchange. The Treasury would pay the credits directly to the insurance carriers for eligible individuals who would pay the balance of the premium to the insurance carrier. For employed individuals who purchase coverage through the exchange, the premium contributions would be made via a payroll deduction.

Choice of Plan

The Senate Finance Committee bill would allow the sale of private plans or health care co-operative plans through the state exchanges. All insurance carriers in the individual and small-group markets that are licensed by a state would be required to offer a plan through the exchanges, and must at least offer silver and gold plans.

The state or secretary of HHS must provide a standardized format for presenting insurance options in the state exchange, including benefits, premiums, and provider networks; develop standardized marketing requirements; develop a rating system for plans entering the exchange, based on relative quality and price compared with other

plans offering products at the same benefit level to be displayed on the exchange Web site. The state or secretary would also develop a model template for a Web portal, to be used by states, that directs individuals and small businesses to available insurance options in their state, provides a tax credit calculator that allows people to determine their premium contribution, informs people of eligibility for public programs, and presents standardized information such as health plan ratings. Agents and brokers are permitted to enroll individuals and employers in any health insurance option available in the state exchanges.

Health cooperatives. The Senate Finance Committee bill authorizes $6 billion in funding the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of nonprofit, member-run health insurance companies. Health care cooperatives are nonprofit, consumer-governed organizations that provide insurance and deliver health services. Group Health Cooperative in Seattle and HealthPartners in Minnesota are examples of consumer governed health co-ops that have competed successfully with private carriers and have a record of delivering high-quality care.[1] The grants would be available to new co-ops that would compete in the reformed individual and small-group markets on a level playing field with other plans. Participants in the program could band together for the purpose of purchasing services, claims administration, health information technology, and other items and could establish a purchasing council. However the purchasing council is prohibited from setting payment rates for providers and could not include members of federal, local, or state governments.

Basic health plans. An amendment to the Senate Finance Committee bill would provide states the option of pooling federal premium and cost-sharing subsidies for people earning between 133 percent and 200 percent of poverty to establish a non-Medicaid, state-based basic health plan, offered by private insurers under contract. The state would negotiate premiums and benefit packages directly with private health plans and offer those policies to people earning between 133 percent and 200 percent of poverty who do not have affordable employer coverage. Sen. Maria Cantwell (D-Wash.) offered the amendment, modeling it on a program in Washington that delivers low-cost care to individuals with incomes just above Medicaid limits. The bill would require basic health plans to meet the Senate Finance Committee bill's minimum benefit package and

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[1] K. Davis, "Cooperative Health Care: The Way Forward?" *The Commonwealth Fund Blog,* June 2009, http://www.commonwealthfund.org/Content/Blog/Health-Cooperatives-The-Way-Forward.aspx; D. McCarthy, K. Mueller, and I. Tillmann, *Group Health Cooperative: Reinventing Primary Care by Connecting Patients with a Medical Home* (New York: The Commonwealth Fund, July 2009); and D. McCarthy, K. Mueller, and I. Tillmann, *HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda* (New York: The Commonwealth Fund, June 2009).

premium and cost-sharing limits for this income level. In addition, participating plans would be required to meet a minimum medical loss ratio of 85 percent. State administrators would seek to contract with managed care systems and provide a choice of more than one plan. State administrators, with HHS, would establish performance measures and standards for participating health care systems that focus on quality of care and improved health outcomes. Health plans would be required to report to the state on these measures, which would also be provided to the HHS secretary and basic health plan enrollees to help in selecting health plans. States could band together to form multistate risk pools for the purposes of negotiating with heath care systems.

Health care choice compacts. The Senate Finance Committee bill would allow two or more states to form health care choice compacts to allow for purchase of individual plans across state lines. Insurers would be able to sell policies in any of the participating states and would only be subject to the laws and regulations of the state where the policy was issued. However, they would have to be licensed in all states in the compact or submit to jurisdiction of laws regarding consumer protection standards, network adequacy, and others.

National plans. The Senate Finance Committee bill would allow national plans with uniform benefit packages to be offered across state lines. The plans would be licensed in each state they operate in and would be regulated by those states and offer coverage through the state exchanges—at least silver and gold plans, as required by other carriers. The plans would have to be compliant with benefit standards established by the bill but would preempt state benefit mandates.

Risk Adjustment and Reinsurance

All plans sold in the individual and small-group markets would be subject to the same system of risk adjustment. The HHS secretary would define qualified risk adjustment models to be used by states, although states could develop their own models that produce the same results. After risk adjustment is applied to plans, reinsurance and risk corridors are then applied.

Reinsurance. As a condition of issuing commercial insurance, major medical health insurance policies, or administering benefit plans for major medical coverage in years 2013, 2014, and 2015, all health insurance issuers would be required to contribute to a reinsurance program for individual policies administered by a nonprofit entity. Contributions must amount to $20 billion over the time period, with $10 billion in 2013,

$6 billion in 2014, and $4 billion in 2015. This is designed to counter adverse selection problems in the early years of the exchange and would be enforced at the state level. However, the new federal requirements would ultimately preempt state law. In addition, $5 billion would be added to the fund for employer-sponsored retiree coverage. The non profit entity would use funds from insurers to support a reinsurance mechanism directed at individuals enrolled in plans offered through state exchanges. Invisible to the individual, the mechanism would define individuals as high risk using a limited list of 50 to 100 high-risk conditions or other comparable method recommended by the American Academy of Actuaries. The formula would be designed on a per-condition basis that encourages the use of care coordination and care management programs for high-risk conditions. For retiree coverage, the program would reimburse any eligible employers or insurers 80 percent of claims between $15,000 and $90,000 for non active workers and dependents ages 55 to 64.

Risk corridors. Risk corridors for health plans offered through the exchange (individual and small-group markets) would be modeled after those applied to regional participating provider organizations in Medicare Part D. If the "allowable costs" (total amount of costs that the plan incurred in providing benefits covered by the plan reduced by administrative expenses) are between 97 percent and 103 percent of the "target amount" (the total annual premium including subsidies minus administrative expenses) plans would receive no payment. If allowable costs were higher than expected, health plans would receive a payment according the following schedule:

- If allowable costs are between 103 percent and 108 percent of the target amount for the plan and year, the secretary would make a payment to the plan of 50 percent of the difference between the allowable costs and 103 percent of the target amount.
- If the allowable costs exceed 108 percent of the target amount, the secretary would pay the plan the sum of 2.5 percent of the target amount plus 80 percent of the difference between allowable costs and 108 percent of the target amount.

On the other hand, if allowable costs were lower than expected, health plans would make a payment:

- If allowable costs were between 97 percent and 92 percent of the target amount, the plan would make a payment to the secretary equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs.

- If allowable costs were below 92 percent of the target amount, the plan would make a payment to the secretary equal to the sum of 2.5 percent of the target amount and 80 percent of the difference between 92 percent of the target amount and allowable costs.

Individual Mandate

Beginning in 2013, all U.S. citizens and legal residents would be required to purchase coverage through: 1) the individual insurance market; 2) a public program such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or the Veterans Health Administration plan; 3) the small-group market, in a plan meeting at least the requirements of the bronze plan; or 4) the large-group market, in a plan that provides first-dollar coverage for prevention services (except in the case of value-based insurance design[2]) and that does not have an "unreasonable annual or lifetime limit on coverage" or a maximum out-of-pocket limit lower than that under HSA law. Individuals and groups who want to renew an existing policy would be permitted to do so, but they could not receive tax credits for them. Individuals would be required to report on their federal income tax return the months for which they maintain the required coverage for themselves and dependents under age 18. Insurers, self-insured employers, and public insurance programs must also report information on health insurance coverage to the covered individual and the Internal Revenue Service, including months of coverage in the tax year and individuals covered on the policy.

Exemptions from the Mandate

Exemptions from the mandate would be made for individuals where the full premium of the lowest-cost option available (net of subsidies and employer contribution, if any) exceeds 8 percent of their adjusted gross income. Available policies are defined as an employer policy in the case of an individual who works for an employer who offers coverage and an individual policy in the case of an individual who does not have access to an employer-sponsored plan. These individuals could purchase the young adults policy, regardless of age. Exemptions from the excise tax would also be made for individuals below 133 percent of poverty until 2014 and 100 percent of poverty, any health arrangement provided by established religious organizations whose members hold sincerely held beliefs (e.g., those participating in Health Sharing Ministries), those experiencing hardship situations (as determined by the HHS secretary, and individuals who are Indian, as defined in Section 4 of the Indian Health Care Improvement Act.

[2] Value-based insurance designs use variable cost-sharing aimed at enhancing the use of appropriate health services and prescription drugs, and discouraging the use of inappropriate services and drugs.

Penalties for Noncompliance

The consequence for not maintaining insurance—for those not exempt from the mandate—would be an excise tax of $750 per adult in the household. This per-adult penalty would be phased-in. In 2013, there would be no penalty; in 2014, the tax would be $200; in 2015, $400; in 2016, $600; and, in 2017, $750. The tax would apply for any period over three months that the individual was not covered but would be prorated for partial years of noncompliance. The tax would be assessed through the tax code and would be applied as an additional amount of federal tax owed.

The bill requires the Government Accountability Office to undertake a study of the affordability of coverage, including the impact of the provision of small business and individual tax credits in maintaining and expanding coverage, the availability of affordable plans, and the ability of Americans to meet the personal responsibility requirement. The report would be made available to the congressional committees of jurisdiction no later than February 1, 2014.

Medicaid Expansion

The Senate Finance Committee bill would establish 133 percent of poverty as the new mandatory minimum Medicaid eligibility level for all nonelderly individuals (i.e., children, parents, childless adults) beginning on January 1, 2014. Existing law would not change for pregnant women. Those newly eligible for Medicaid under the expansion would receive a “benchmark” or “benchmark-equivalent” benefit package that states can currently provide to some populations as an alternative to all the mandatory benefits under traditional Medicaid. The benchmark plan options include the Blue Cross/Blue Shield Standard plan in the Federal Employees Health Benefits Program, a plan offered to state employees, the largest health maintenance organization (HMO) in the state, and other coverage for targeted populations approved by the HHS secretary. Benchmark-equivalent coverage must have the same actuarial value as one of the benchmark plans.

During 2013, individuals with incomes under 133 percent of poverty would not be subject to the individual mandate, nor would they be eligible for tax credits through state exchanges. States would be required to maintain existing income eligibility levels for all Medicaid populations until the state exchanges become operational in July 2013. Between January 2011 and January 2014, a state is exempt from maintaining existing income eligibility levels effort for optional nonpregnant, nondisabled adult populations above 133 percent of poverty, if the state certifies that it is experiencing a budget deficit or projected to have a deficit.

Beginning in 2014, individuals with income below 100 percent of poverty would be eligible for Medicaid and would not be eligible for tax credits through the exchange. Nonelderly, nonpregnant adults with incomes between 100 percent and 133 percent of poverty would choose between Medicaid or subsidized coverage through their state exchange. Children with coverage through the exchange would be entitled to the same benefits and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit they are entitled to under Medicaid. The Medicaid cost-sharing rules and out-of-pocket limit of 5 percent of income would continue to apply to children.

States can now offer premium assistance to Medicaid-eligible individuals if they are offered employer coverage that is less expensive than the state's expected costs of providing Medicaid. States must cover premiums and cost-sharing and provide wraparound benefits. Under the bill, states would be required to offer premium assistance and wraparound benefits to Medicaid beneficiaries who are offered employer coverage, consistent with current law requirements.

In January 2014, income disregards would no longer apply (states are currently allowed to disregard certain types of income) and eligibility for Medicaid would be based on modified gross income as defined in state exchanges, except for certain populations.

Federal Medicaid Payments to States

The federal share for most Medicaid costs is determined by the Federal Medical Assistance Percentage (FMAP), which is based on a formula that provides higher reimbursement to states with lower per-capita incomes relative to the national average. FMAPs have a statutory minimum of 50 percent and maximum of 83 percent. Under the Senate Finance Committee bill, states would continue to receive federal financial assistance as determined by FMAP. Beginning in 2014, additional federal financial assistance would be provided to all states to defray the costs of covering newly eligible beneficiaries. The federal government would pay a greater share of the costs for individuals newly eligible for Medicaid, subject to a cap of 95 percent. States that already cover adults with incomes over 100 percent of poverty would receive an increase in their FMAP of 27.3 percentage points and states that currently do not would receive an increase of 37.3 percentage points. By 2019, all states would receive the same level of additional assistance or an increase of 32.3 percentage points. A modification to the bill would provide full federal funding for newly eligible beneficiaries from 2014 to 2018 in states where Medicaid enrollment as a share of population is below the national average

at the date of enactment of the bill or with seasonally adjusted unemployment rates of 12 percent or more in August 2009.

Children's Health Insurance Program

As amended, the Senate Finance Committee bill would maintain the current structure of CHIP which provides health insurance to children in families above Medicaid eligibility levels. States would be required to maintain income eligibility levels for currently eligible children in Medicaid and CHIP, though this would expire in December 2019. States would be able to expand their income eligibility levels at any time. Currently, states receive an enhanced FMAP for the program. Under the bill, those payments would increase in 2014 by 23 percentage points through 2019, subject to a cap of 100 percent.

Employer Shared Responsibility

The Senate Finance Committee Bill requires companies with more than 50 full time employees to pay a flat fee for each employee who receives tax credit through an exchange. The flat fee would be equal to the national average tax credit and would not be linked to the individual, but would be contributed to a general fund. The employer would pay the lesser of the flat dollar amount multiplied by the number of full-time employees receiving a tax credit or a fee of $400 per employee paid on its total number of full-time employees, regardless of how many are receiving the state exchange credit.

Exemptions for Small Businesses

Small businesses with fewer than 50 full-time employees would be exempted from the requirement.

Premium Subsidies for Small Businesses

The Senate Finance Committee bill would provide tax credits to qualifying small business for a maximum of two years. In phase 1 (2011–2012), a tax credit up to 35 percent of employer premium contribution (must be at least 50% of premium) would be available for employers with fewer than 25 employees, with average wages below $40,000. The full amount of credit is available to employers with 10 employees, or average wages of $20,000, and phases out. In phase 2 (beginning in 2013), a tax credit up to 50 percent of employer premium contribution (must be at least 50% of premium) would be available for employers with fewer than 25 employees, with average wages below $40,000 and who buys plans through the exchange. The full amount of the credit is available for employers with fewer than 10 full-time employees and average wages below $20,000. The credit phases out for firms with 10 to 25 employees (at a rate of 6% of base

credit percentage for each employee above 10) and average wages of $20,000 to $40,000 (at a rate of 5% for each $1,000 increase of average wages above $20,000).

Tax-exempt organizations are eligible to receive small-business tax credits, though they are somewhat lower: 25 percent of employer contribution to premium in phase 1 (2011–12), compared with 35 percent for other companies; and 35 percent in phase 2, beginning in 2013, compared with 50 percent for other companies.

II. DELIVERY SYSTEM REFORM PROVISIONS

Investing in Primary Care

The Senate Finance Committee bill includes a number of provisions that would strengthen the primary care system in the U.S. In the traditional Medicare fee-for-service (FFS) program, physicians who treat Medicare beneficiaries are paid separately for each service they provide. Currently, cognitive services and primary care services are relatively undervalued compared with procedures and specialty care. Despite our projected growing need for primary care providers to serve an aging population, the market signal of lower pay and long hours has resulted each year in fewer medical school graduates choosing primary care careers over specialties. To improve financial incentives, Medicare reimbursement rates for primary care physicians, as well as general surgeons serving in underserved areas, would increase by 10 percent for five years. This action would be funded by cutting reimbursement for other services by 0.5 percent.

The Senate Finance Committee bill makes primary care more accessible for Medicare beneficiaries by removing cost-sharing for preventive services and introducing a new comprehensive health risk assessment. Cost-sharing is eliminated from all preventive services covered by Medicare and those rated "A" or "B" by the U.S. Preventive Services Task Force. The bill allows the HHS secretary to not reimburse providers for preventive services rated "D" or harmful by the U.S. Preventive Services Task Force, saving an estimated $700 million over 10 years.[3] The comprehensive health risk assessment, to identify chronic diseases, modifiable risk factors, and emergency or urgent health needs, would be available to every beneficiary. This assessment can be completed prior to or as part of an annual wellness visit. In addition, Medicare would include coverage for the development of a personalized prevention plan created by the beneficiary's primary care physician. Furthermore, all beneficiaries would be entitled to

[3] Congressional Budget Office, Letter to the Honorable Max Baucus, October 7, 2009, http://www.cbo.gov/doc.cfm?index=10642; Title II, Subtitle A, Evidence-Based Coverage of Preventive Services.

an annual wellness visit, to which no copayments or deductibles apply. In the first year of enrollment, beneficiaries would be eligible for either an initial preventive physical examination or the annual wellness visit, but not both visits.

Finally, the bill requires private insurers to create plans that do not include cost-sharing for preventive services. This provision would not apply to grandfathered plans or those that use value-based insurance design.

Physician Fee Updates

The sustainable growth rate (SGR) mechanism was established as part of the Balanced Budget Act of 1997 to control the growth in aggregate Medicare expenditures for physician services. The premise of SGR was to control spending on physician's services with annual adjustments to reflect differences between actual spending and a spending target pegged to overall economic growth. Physician payment rates would increase if cumulative spending were below the target and decrease if spending were above target.[4] However, in recent years the SGR has produced large decreases in physician fees, which Congress has overridden without changing the underlying mechanism, most recently through the Medicare Improvements for Patients and Providers Act (MIPPA) in 2008.[5] As a result, the gap between target and actual spending has steadily increased, leading to a 21 percent cut in Medicare physician fees scheduled for January 2010. Under the bill, physician fees in 2010 would increase by 0.5 percent. No comprehensive change to the SGR is included in the Finance Committee bill; instead, the Senate is considering a permanent fix to the SGR through standalone legislation.[6]

Geographic Variations in Physician Expenses

The Medicare fee schedule consists of three components—physician work, practice expense, and medical malpractice insurance costs—each of which is adjusted by a separate geographic practice cost index (GPCI) to reflect differences in the local cost of resources needed to produce physician services. An index value of 1.00 represents the national average, with a value of 0.95 indicating local costs 5 percent below the average and a value of 1.05 indicating local costs 5 percent above. However, the three GPCIs are applied in ways that do not adjust directly for measured cost differences: for example, the GPCI applied to the physician work component of the fee schedule has a minimum value

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[4] D. B. Marron, CBO Testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives on Medicare's Physician Payment Rates and the Sustainable Growth Rate, July 25, 2006.

[5] Medicare Improvements for Patients and Providers Act (MIPPA), Public Law 110-275.

[6] S. 1776, Medicare Physician Fairness Act of 2009.

of 1.00—that is, every area is treated as though it has at least the average level of input costs. The Finance Committee bill extends this floor for an additional two years. In addition, the bill adjusts the GPCI for practice expenses in lower cost areas by blending the local index for those areas with the national average. The bill does not make any change to the GPCI for medical malpractice.

Pilots for Rapid-Cycle Testing of Innovative Payment Methods

The Finance Committee bill includes the establishment of a Centers for Medicare and Medicaid Services Innovation Center, authorized to test, evaluate, and expand the application of payment methodologies that would facilitate patient-centered care, improve quality, and contain cost growth in Medicare. After rigorous evaluation, models that meet certain criteria, including patient-centered care, can be approved for expansion by the HHS secretary.

Medical Homes

The Finance Committee bill expands upon the existing Medicare medical home demonstration project to allow states the option of permitting Medicaid beneficiaries with two or more chronic conditions or one chronic condition with a risk of a second to designate a provider as a medical home. An amendment offered by Sen. Jay Rockefeller (D–W.V.) and adopted by the committee ensures that serious and persistent mental health conditions qualify in this provision. The qualifications of a medical home would be defined by the HHS secretary and would include comprehensive care management, care coordination, comprehensive transitional care, patient and family support, and referral to community and social support services. Providers designated as a medical home must report on applicable quality measures, particularly avoidable hospital readmissions, and would be reimbursed for their additional services with extra federal support. After two years, the program would be evaluated for its impact on reducing hospital admissions.

Accountable Care Organizations

The Finance Committee bill allows eligible providers to be recognized as accountable care organizations (ACO) and to share in the savings they produce for Medicare. To qualify as an ACO, groups must include providers and suppliers with a mechanism for joint decision making, agree to be responsible for the overall care of their Medicare beneficiaries, include primary care physicians for at least 5,000 Medicare beneficiaries, define processes to promote evidence-based medicine, report on quality and costs measure, and coordinate care and meet certain quality thresholds. ACOs must report certain quality data to CMS. If, over the span of three years, the organization’s costs are

below a certain benchmark (determined by the HHS secretary), the ACO would be eligible for shared savings.

In addition, the bill authorizes a demonstration project to allow pediatric providers to form ACOs under Medicaid. Participating providers would be eligible to share in the federal and state cost savings they achieve for Medicaid and CHIP.

Hospital Readmissions and Bundled Fees

Reducing hospital readmissions both improves the quality of care that patients receive and reduces costs. As part of the Finance bill, the HHS secretary would be required to develop, test, and evaluate alternative payment methods through a national, voluntary pilot program that is designed to provide incentives for providers to coordinate patient care and to be jointly accountable for the entire episode of care. If evaluations find that the pilot program achieves its goals of improving patient outcomes, reducing costs, and improving efficiency, then the secretary would be required to submit an implementation plan to Congress on making the pilot a permanent part of the Medicare program.

In addition, the bill reduces payments for hospitals with high readmissions rates for selected conditions. CMS would calculate national and hospital-specific readmissions rates and share this data with hospitals and the public. Beginning in 2013, hospitals in the highest quartile of readmissions rates over a 30-day period for selected conditions would be subject to a reduced payment policy. Hospital reimbursements for the original hospitalization for selected conditions would be reduced by 20 percent if a patient is rehospitalized for a preventable condition within seven days of discharge. The original payment would be reduced by 10 percent if the patient is rehospitalized in 15 days. After three years, the secretary would have the option of expanding the policy.

In addition, the Finance bill requires CMS to establish a three-year pilot program in Medicare, the Community Care Transitions Program. This program would fund eligible organizations to provide transition services for Medicare beneficiaries at highest risk of preventable rehospitalization. The program would be expanded if it improves quality of care and reduces projected Medicare spending.

Cost-Containment

The Finance bill establishes a new Medicare commission to submit proposals to Congress that would extend Medicare solvency, slow Medicare cost growth, and increase quality of care. Under an amendment proposed by Sen. Rockefeller and approved by the Senate

Finance Committee, the recommendations provided by the new Medicare commission would be considered binding unless the Senate votes with a two-thirds majority to reject them or offers an alternative plan with equivalent savings.

The current method of setting benchmarks for payments to Medicare Advantage plans results in payments estimated to average 13 percent higher than costs would have been under the traditional Medicare FFS program. As the system now works, plans submit bids for covering Medicare beneficiaries based on their expected costs for providing coverage. The bid is then compared with benchmark rates for each county. If the plan's bid is below the benchmark, the plan receives a payment equal to the amount bid plus 75 percent of the difference between the bid and the benchmark; the additional amount must be matched by additional benefits provided to the beneficiaries who enroll in the plan, either through coverage of additional services or reductions in premiums or out-of-pocket costs. In every county, benchmark rates exceed the costs expected under traditional Medicare FFS, and this gap is greater in some areas than in others.

Under the bill, payments to Medicare Advantage plans would be restructured and based on a weighted average of plan bids. Bonus payments for quality, performance improvement, care coordination, and efficiency would be added. To ease the transition, the secretary would have to provide additional transitional benefits to beneficiaries who experience a serious reduction in benefits under competitive bidding. The bill allows plans to grandfather policies in areas where plan bids are at or below 75 percent of the local FFS reimbursement rates. The amount of extra benefits thus provided would be reduced by 5 percent each year, beginning in 2013. Other requirements, such as one that plans bid in areas where they have grandfathered enrollees and that grandfathered enrollees would not be eligible for performance bonus payments, would apply.

Other, more targeted provider payment changes would be made as well. Provider payments would be modified by reducing market basket updates by 1 percent annually to account for productivity improvement. Federal payments for health care-acquired conditions would be prohibited under the Medicaid program.

Furthermore, hospitals in the top quartile of national, risk-adjusted hospital acquired condition rates would have all Medicare payments reduced by 1 percent one year after being notified of their status. Payment rates for specific types of care, such as home health, hospice, oxygen rental and equipment, and power wheelchairs, would be updated as well.

To reduce fraud, waste, and abuse, the bill requires that providers and suppliers be screened before they are granted Medicare billing privileges.

Quality Improvement

The Senate Finance bill directs the HHS secretary to develop a national strategy to improve health care quality. This strategy would be a comprehensive approach to improve the delivery of health care services, patient health outcomes, and population health. The strategy would include a plan to achieve the priorities outlined by the secretary, including provisions for addressing coordination among agencies within HHS; agency specific strategic plans and benchmarks; and strategies to align incentives among public and private payers. The strategy would be updated at least three times per year.

The president would convene an interagency working group of relevant federal departments and agencies to collaborate on the national quality improvement strategy and priorities. The group would submit a report to the secretary annually to provide recommendations for the national strategy.

In addition, the bill calls on the secretary to identify quality measures that should be developed or enhanced three times per year. These measures would be identified by the qualified consensus-based entity set forth in MIPPA. To develop or improve these measures, the secretary would provide grants to an external, qualified entity. The measures must build on other reported measures; be collected using health information technology, if possible; be free of charge to users of measures; and be publicly available on the internet. To fund these grants, the bill appropriates $75 million to the secretary annually.

The Finance bill requires the secretary to apply a separate, budget-neutral payment modifier to the Medicare physician fee schedule. This modifier would pay physicians differentially based upon the relative quality of care they provide for Medicare beneficiaries. The standards upon which the modifier would be based must be published by 2012, and the secretary must, by 2014, provide physicians with information on the value of care they provide. All physician payments would be subject to the modifier by 2017.

To complement Medicaid/CHIP’s quality measurement programs for children’s care, the Medicaid quality measurement program would also establish priorities for the development and advancement of quality measures for adults with coverage in the Medicaid program.

To ensure that quality measures are reported and used effectively to improve care, the Finance bill implements new quality and performance reporting programs to facilitate public access. The bill requires improved and uniform collection and reporting of data on race, ethnicity, sex, language, and disability to address health disparities.

Comparative Effectiveness

The Chairman's Mark creates the Patient-Centered Outcomes Research Institute to identify national priorities for comparative clinical effectiveness research and establishing a research agenda. This institute would facilitate decision-making by patients, providers, purchasers, and policymakers by providing timely and relevant clinical research. The research would compare the clinical effectiveness, risk, and benefits of two or more medical treatments, services or items, allowing stakeholders to effectively compare different treatment regimens. The institute would not, however, be permitted to make policy, coverage, or practice recommendations. Research by the institute could not be used to either mandate or deny coverage based solely on findings. Research would be funded by the Patient-Centered Outcomes Research Trust Fund, which would receive $1.26 billion in funds from the Treasury beginning in 2010.

III. FINANCING AND REVENUE PROVISIONS

Under the Congressional Budget Act of 1974, the Congressional Budget Office (CBO) is directed to score the impact legislation has on the federal deficit relative to the federal baseline projections. Under the Act, the Joint Committee on Taxation (JCT) is also required to estimate the impact on revenues when legislation involves the tax code and CBO is required to incorporate JCT estimates into its analysis. All estimates in this description are in billions unless otherwise noted and refer to cumulative savings over the 10-year window, 2019–2019.

Provider Payment Changes and Productivity Update

The Medicare FFS payment policy reimburses physicians and caregivers at a variety of institutions based on preset fee schedules. The base payment rates are updated annually to reflect changes in the price of medical services. Without further congressional action, Medicare would face a 21.5 percent decrease in payment rates for physician services in 2010 under the Sustainable Growth Rate formula. The Finance Committee bill would address this problem in 2010 by overriding it with an increase of 0.5 percent, at a cost of $11 billion. No comprehensive change to the SGR is included in the Finance Committee bill; instead, the Senate is considering a permanent fix to the SGR under standalone

legislation.[7] If a permanent solution to the SGR formula is not implemented, Medicare providers face another scheduled reimbursement rate cut of nearly 25 percent in 2011.[8]

CBO estimates that other provisions in the Finance Committee bill intended to make Medicare and Medicaid more efficient would yield $415 billion in savings, totaling $404 billion in net savings over the 10-year period, 2010–2019.

Separate from the one-year change to the SGR, the Finance Committee bill would hold increases in payment rates for all non-physician providers below the rate of inflation to account for expected ongoing productivity improvements.[9] These market basket cuts are estimated to yield $162 billion in savings over 10 years.

Medicare Advantage Reforms

The Finance Committee bill makes a number of changes to the Medicare Advantage program, most notably transitioning to competitive bidding and private FFS plans. CBO estimates that these changes would yield $130 billion in savings over 10 years.[10]

Disproportionate Share Hospital Adjustment

Hospitals that serve a disproportionately large number of low-income patients can receive higher Medicare and Medicaid payments through the disproportionate share hospital (DSH) adjustment. The Finance Committee bill would reduce Medicare and Medicaid DSH payments starting in 2015 to reflect lower uncompensated care costs relative to increases in the number of uninsured, providing $45 billion in savings through 2019.[11]

Independent Medicare Commission

The Finance Committee bill would establish a 15-member, independent Medicare commission to present Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. The Commission's proposals to Congress would extend Medicare solvency, improve quality of care, and reduce excess cost growth by 0.5 percent in 2015. Unless voted down by a two-thirds

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[7] S. 1776, Medicare Physician Fairness Act of 2009.

[8] Congressional Budget Office, Letter to the Honorable Max Baucus, Sept. 16, 2009, http://www.cbo.gov/doc.cfm?index=10572&zzz=39579.

[9] Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642; Title III, Subtitle E, Market Basket Cuts.

[10] Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642; Title III, Subtitle C, & Medicare Advantage Interactions.

[11] Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642; Title I, Part VI; and Title III, Subtitle D, Medicare DSH Changes.

majority, the Commission's proposal would automatically go into effect. The proposals would be required to reduce excess cost growth by 1 percent in 2016, 1.25 percent in 1017, and 1.5 percent in 2018.[12] CBO estimates that the commission would yield $22 billion in savings from 2010 to 2019.[13]

Innovative Payment Methods

A number of innovative provider payment methods are included in the Finance Committee bill in an effort to better link payment to quality outcomes in Medicare, including hospital value-based purchasing; the physician quality reporting initiative; expansion of the physician feedback program; quality reporting for inpatient rehabilitation facilities, long-term acute care hospitals, and hospices; a CMS payment innovation center, and accountable care organizations. Overall, CBO estimates that these provisions would provide $10 billion in savings over 10 years.[14]

Changes to Home Health Payments

Home health agencies currently receive a single prospectively determined payment to cover all a beneficiary's services for a 60-day period. This single amount is determined by a national base payment rate adjusted to account for differences in patients' case mix, for geographic variation of prices, and for extraordinarily costly patients (through outlier adjustments). The base payment is updated annually. The Finance Committee bill would implement a provider-specific cap on home health outlier payments, effecting a 2.5 percent payment reduction, and would provide add-on payments to ensure access to care and quality services, resulting in $33 billion savings over 10 years.[15]

Reducing Hospital Readmissions

Under the Finance Committee bill, starting in 2013, hospitals with readmission rates above a certain threshold would face reduced reimbursements for select conditions.[16] CBO estimates that this provision would yield $2 billion in savings from 2010 to 2019.[17]

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[12] America's Healthy Future Act of 2009, Chairman's Mark, Sept. 16, 2009, http://finance.senate.gov/sitepages/leg/LEG%202009/091609%20Americas_Healthy_Future_Act.pdf, Title III, Subtitle E, Medicare Commission.

[13] Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642; Title III, Subtitle E, Medicare Commission.

[14] Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642; Title III, Subtitle A, Part I; and Title III, Subtitle A, Part III, Accountable Care Organizations and CMS Innovation Center.

[15] Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642; Title III, Subtitle D, Home Health Payment Changes.

[16] Conditions determined by the Secretary of Health and Human Services based on spending and readmission rates.

Primary Care, Prevention, and Geographic Adjustments
To strengthen the primary care workforce, the Finance Committee bill would provide a primary care/general surgery bonus and would invest in graduate medical education for those interested in a career in primary care. In addition, the bill would authorize the secretary of HHS to correct geographic disparities in Medicare payment rates between rural and non-rural providers. These provisions would cost an estimated $4 billion from 2010 to 2019.[18]

Prescription Drug Payment Rate Changes
The Finance Committee bill makes a number of improvements to the Medicare prescription drug benefit, including improving coverage in the Part D coverage gap (known as the "doughnut hole"), requiring more transparency of pharmaceutical benefit managers offering plans in the health insurance exchange, improving the determination of Part D low-income benchmarks, and reducing the Part D premium subsidy for high-income beneficiaries. In total, these changes result in an additional federal cost of $1 billion over 10 years.[19]

Other Improvements and Interactions Between Reforms
The Finance Committee bill includes a wide range of other provisions to improve the quality and efficiency of Medicare and Medicaid, such as reducing fraud, waste, and abuse; ensuring beneficiary access to physician care and other services; establishing a new CMS innovation center to test and evaluate different patient care models; and promoting disease prevention and wellness. These changes, along with the effect of interactions between various provisions, yield an estimated $16 billion in savings from 2010 to 2019.[20]

Increased Revenues
Along with the system savings described above, new revenues outlined in the Finance Committee bill more than outweigh the cost of expanding and improving coverage. The Joint Committee on Taxation estimates that the modified Finance Committee bill would

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[17] Congressional Budget Office, Letter to the Honorable Max Baucus, Sept. 16, 2009, http://www.cbo.gov/doc.cfm?index=10572&zzz=39579; Title III, Subtitle A, Part III, Reducing Avoidable Hospital Readmissions.
[18] Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642; Title III, Subtitle A, Part IV.
[19] Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642; Title III, Subtitle B, Part III.
[20] Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642.

produce $397 billion in new revenues from 2010 to 2019. Of that amount, $196 billion would come from provisions modifying flexible spending and health savings accounts; new annual fees on manufacturers and importers of drugs and devices and on health insurance providers; and changes to some tax deductions.[21] The remainder would come from a new excise tax.

Excise Tax on High-Premium Insurance Plans

Levying a new excise tax on high-premium health insurance plans accounts for $201 billion in increased revenues over 10 years. For policies that cost in excess of $8,000 for an individual and $21,000 for a family, a 40 percent excise tax would be applied to the insurers writing the policy.

The thresholds are indexed at the Consumer Price Index for Urban Consumers, plus 1 percent beginning in 2014.[22] For retired individuals over age 55 with employer-sponsored coverage, the threshold is increased to $10,000 for individuals and $25,000 for family coverage. In addition, employees that are engaged in high-risk professions are also subject to the higher thresholds. Such professions include law enforcement officers, firefighters, members of a rescue or ambulance crew, and individuals engaged in construction, mining, agriculture, and forestry or fishing industries.

Recognizing that insurance premiums vary greatly across the country, there is transition relief for the 17 highest-cost states for three years.

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[21] "Estimated Revenue Effects Of The Revenue Provisions Contained In Title VI Of The 'America's Healthy Future Act Of 2009,' As Amended Through October 2, 2009, And Under Consideration By The Committee On Finance," Joint Committee on Taxation, October 8, 2009, JCX-41-09, http://www.jct.gov/publications.html?func=startdown&id=3590.

[22] As determined by the Department of Labor.

SOURCES

Congressional Budget Office, Letter to the Honorable Max Baucus, Oct. 7, 2009, http://www.cbo.gov/doc.cfm?index=10642.

Congressional Budget Office, Letter to the Honorable Max Baucus, Sept. 16, 2009, http://www.cbo.gov/doc.cfm?index=10572&zzz=39579.

Estimated Revenue Effects of the Revenue Provisions Contained in Title VI of the 'America's Healthy Future Act Of 2009,' as Amended Through October 2, 2009, and Under Consideration by the Committee on Finance, Joint Committee on Taxation, Oct. 8, 2009, JCX-41-09, http://www.jct.gov/publications.html?func=startdown&id=3590.

America's Healthy Future Act of 2009, S. 1796, 111th Cong., 1st sess. (Oct. 19, 2009).

Chairman's Mark, *America's Healthy Future Act of 2009,* Oct. 2, 2009, http://www.finance.senate.gov/sitepages/leg/LEG%202009/100209_Americas_Healthy_Future_Act_AMENDED.pdf.

Henry J. Kaiser Family Foundation, *Health Care Reform Proposals,* Oct. 15, 2009, http://www.kff.org/healthreform/upload/healthreform_tri_full.pdf.