APPENDIX A

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
U.S. SENATE

AS PASSED BY THE SENATE ON DECEMBER 24, 2009

I. INSURANCE COVERAGE PROVISIONS

Insurance Market Reforms

The Senate bill would establish new federal rules for the individual and small-group markets, 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 3:1), tobacco use (maximum 1.5:1), family composition, participation in a health promotion program, and geography. 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. Beginning in 2010, insurers in the individual and group markets would be prohibited from rescinding coverage and would be prohibited from imposing lifetime benefit limits and unreasonable annual limits. All annual limits on benefits would be prohibited beginning in 2014. Health insurers would be prohibited from excluding preexisting conditions from coverage for children beginning immediately. Health plans would be required to report the proportion of premiums spent on items other than medical care beginning in 2010. Beginning in 2011, health plans would be required to refund enrollees for non-claims costs that exceed 15 percent in the large group market and 20 percent in the small group and individual markets. Beginning in 2014, all individual and group health plans would be prohibited from requiring a waiting period for coverage of more than 90 days. All insurers and employers would be required to cover dependents up to age 26, beginning in 2010. All group and individual market plans would be required to provide first-dollar coverage for preventive services, beginning in 2010. The federal government would provide $30 million in grant funds to states in 2010 for consumer assistance or ombudsman programs. In 2010, an internet portal would be established to help people choose insurance plans.

People who have been uninsured for at least six months who have been denied coverage because of a preexisting condition would be eligible for subsidized coverage through a temporary national high-risk pool program to be established by the secretary in 2010. High risk pools would not impose preexisting condition exclusions and plans would be required to cover not less than 65 percent of medical costs on average (actuarial value), and limit out-of-pocket spending to that which is defined for health savings accounts (HSA) or $5,950 for individual policies and $11,900 for family policies. Premiums would be set for a standard population and could not vary by more than a factor of four based on age (i.e., 4:1 age bands). The secretary would receive $5 billion to carry out the program.

Health Insurance Exchange

The Senate bill would require each state to establish an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange by 2014 for individuals and small employers. States can opt to provide just one exchange for individuals and small employers. Groups of states could form regional exchanges or states could form more than one substate exchange, but they must serve a geographically distinct area. Neither the individual market nor the small group markets would be replaced by the exchanges, but the same market rules would apply inside and outside the exchange. Premium subsidies could only be used for plans purchased through the exchanges. If the secretary of HHS determines in 2013 that a state will not have an exchange operational by 2014, the secretary is required to establish and operate an exchange in the state. In 2017, states would have the opportunity to opt out of the federal requirements through a five-year waiver, if they were able to demonstrate that they could offer all residents coverage at least as comprehensive and affordable as that required by the bill.

The secretary's responsibilities with respect to the exchanges include: establishing certification criteria for "qualified health plans" that will be sold through the exchanges; requiring such plans to provide the essential benefits package; requiring that the licensed insurance carriers issuing plans offer at least one qualified health plan at the silver and gold levels and meet marketing requirements; ensuring a sufficient choice of providers; and ensuring that essential community providers are included in networks, are accredited on quality, implement a quality improvement strategy, use a uniform enrollment form, present plan information in a standard format, and provide data on quality measures. In addition the secretary would develop a rating system for qualified health plans and a model template for an exchange's internet portal, and determine an initial and open enrollment period, as well as special enrollment periods for people under varying

circumstances. The secretary is also required to establish procedures under which states may allow agents or brokers to enroll individuals in qualified health plans and assist them in applying for subsidies.

The state exchanges would be required to certify qualified health plans, operate a toll-free hotline and internet Web site, rate qualified health plans, present plan options in a standard format, inform individuals of eligibility of Medicaid and CHIP, provide an electronic calculator to calculate plan costs, and grant certifications of exemption from the individual requirement to have health insurance. Exchanges would be required to be self-sustaining by 2015 and would be allowed to charge assessments or user fees. The exchanges also would be required to award grants to "navigators" that educate the public about qualified health plans, distribute information on enrollment and subsidies, facilitate enrollment, and provide referrals on grievances.

Who Is Eligible to Participate?

The Senate bill allows individuals and employers with up to 100 employees—or 50 employees in a state option until 2016—to purchase coverage through the exchange. Beginning in 2017, states would have the option to allow small businesses with more than 100 employees to purchase coverage through the exchange.

The Senate bill would require that members of Congress and their staffs only be offered qualified health plans through the exchanges.

Standard Benefits Package

The Senate 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 all health plans must cover, at a minimum. In addition, plans could charge no cost-sharing (e.g., deductibles, copayments) for preventive care services. Plans could not include lifetime limits on coverage or unreasonable annual limits on any benefits. Beginning in 2014, all annual limits on benefits would be prohibited.

The bronze package would represent minimum creditable coverage with an actuarial value of 60 percent (i.e., covering 60 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 $11,900 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 package would cover 90 percent of costs with the same out-of-pocket limits. A catastrophic benefit package could be made available for adults younger than age 30, similar to HSA-eligible, high-deductible plans, with the essential benefits package, preventive services excluded from the deductible as under current HSA law, three primary care visits, and cost-sharing to HSA out-of-pocket limits. 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, regardless of age.

Deductibles of greater than $2,000 for individuals and $4,000 for families would be prohibited in the small-group market.

The Senate bill requires insurers to pool the risk of all individual enrollees in all plans, except those that are grandfathered, inside and outside the exchanges, and all small group enrollees inside and outside the exchange. If the state combines the individual and small group markets, insurers would pool the risks of both individual and small group enrollees inside and outside the exchanges. Insurers that provide qualified plans would be required to charge the same premium inside and outside the exchanges.

Sliding-Scale Premium and Cost-Sharing Subsidies

The Senate 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 60 percent (i.e., the bronze plan offered through the exchange) or their premium contribution exceeded 9.8 percent of income. Credits would be available for individuals and families earning between 100 percent and 400 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 9.8 percent of income for those earning between 300 percent and 400 percent of poverty. However, people with incomes of less than 133 percent of poverty would be eligible for Medicaid.

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 $1,983 for individuals and $3,967 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 $3,967 for individuals and $7,933 for families. Cost-sharing is eliminated for preventive services.

Choice of Plan

The Senate bill would allow the sale of private insurance plans or health care cooperative plans through the state exchanges. The federal Office of Personnel Management (OPM) would contract with private insurance carriers to offer multistate plans through each exchange. At least one of the new multistate plans must be nonprofit. All insurers participating in the exchange would be required to offer coverage in the silver and gold categories, at a minimum.

Multistate plans. The Senate bill requires the federal office of personnel management (OPM) to contract with health insurers to offer at least two multistate qualified health plans (at least one nonprofit) through the exchanges in each state. OPM would negotiate contracts similar to the way in which it currently negotiates contracts for the Federal Employees Health Benefits Program (FEHBP). The bill allows OPM to prohibit multistate plans that do not meet standards for medical loss ratios, profit margins, and premiums. Multistate plans would be required to cover essential health benefits and meet all of the requirements of a qualified health plan. States may require multistate plans to offer additional benefits, but they must pay for the additional cost. Multistate plans must comply with 3:1 age rating, except where states require more protective age rating. Multistate plans must comply with the minimum standards and requirements of FEHBP, unless they conflict with the Senate bill. The bill stipulates that that FEHBP will maintain a separate risk pool and remain a separate program.

Health cooperatives. The Senate bill authorizes $6 billion in funding for 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. Priority would be given to plans that operate on a statewide basis, will utilize integrated care models, and have significant private support. The secretary shall ensure that there is sufficient funding to establish at least one qualified nonprofit health insurance issuer in each state.

Basic health program. The Senate bill would require the secretary to establish a Basic Health Program which would allow 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 standard health plan, offered by private insurers under contract. The state would negotiate premiums, cost-sharing, 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. This program is modeled on a program in Washington that delivers low-cost care to individuals with incomes just above Medicaid limits. The bill would require standard health plans to meet the minimum benefit package. States must ensure that eligible individuals do not pay higher premiums than they would pay in the exchange, and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with incomes below 150 percent of poverty or the gold plan for all other enrollees. Individuals with incomes between 133 percent and 200 percent of poverty in states that create basic health plans will not be eligible for subsidies in the exchange. 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. States could band together to form multistate risk pools for the purposes of negotiating with heath care systems.

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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).

Health care choice compacts. The Senate bill would allow two or more states to form health care choice compacts to allow for purchase of individual plans across state lines, beginning in 2016. 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 written or issued, except for issues pertaining to market conduct, unfair trade practices, network adequacy, and consumer protections. However, they would have to be licensed in all states in the compact or comply as if they were licensed, and would have to clearly notify consumers that a policy may not be subject to all laws and regulations of the purchaser's state.

Risk Adjustment and Reinsurance

The Senate bill includes temporary and permanent mechanisms aimed at equalizing risks across patients, thereby compensating insurance carriers for high-cost patients, and reducing the incentive for carriers to "cherry pick" good health risks.

Transitional Reinsurance. All states must establish a nonprofit reinsurance entity for 2014, 2015, and 2016 to collect payments from all insurers in the individual and group markets and make payments to such insurers in the individual market that cover high-risk individuals. The secretary of HHS would be required to establish federal standards for the determination of high-risk individuals, a formula for payment amounts, and contributions required of insurers. Contributions from insurers must amount to $25 billion over the three-year time period. This is designed to counter adverse selection problems in the early years of the exchange. In addition, $5 billion would be added to the fund for employer-sponsored early retiree coverage. The nonprofit entity would use funds from insurers to support a reinsurance mechanism directed at individuals enrolled in plans offered through state exchanges. For retiree coverage, the program would reimburse any eligible employers or insurers for 80 percent of claims between $15,000 and $90,000 for nonactive workers ages 55 to 64 and their dependents. The funds must be used to lower the costs borne directly by beneficiaries, and the program incentivizes plans to implement programs and procedures to better manage chronic conditions.

Risk corridors. The bill requires the secretary of HHS to establish and administer a risk corridor program for qualified health plans offered in the individual and small-group markets in 2014, 2015, and 2016. The program 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 103 percent of the target amount for the plan and year, the secretary would make a payment to the plan. On the other hand, if allowable costs were lower than 97 percent of the target amount, the plan would make a payment to the secretary.

Risk Adjustment. Under this permanent program, the Senate bill would require states to develop methods and criteria with the secretary by which they would charge health plans offered in the individual and small-group markets that had lower health risks among their enrollees compared with all plans (excluding self-insured plans), and pay those with higher risks compared with all plans (excluding self-insured plans). The risk adjustment would apply to plans in individual and small-group markets but not grandfathered plans.

Individual Mandate

Beginning in 2014, all U.S. citizens and legal residents would be required to maintain minimum essential health insurance 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) minimum essential benefits offered by employers. Individuals, families, and employers that want to renew an existing policy would be permitted to do so under a "grandfather" provision, 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 with incomes below 100 percent of poverty, individuals with religious

objections, any health arrangement provided by established religious organizations whose members hold sincerely held beliefs (e.g., those participating in Health Sharing Ministries), those experiencing financial hardship situations (as determined by the HHS secretary), those without coverage for less than three months, American Indians (as defined in Section 4 of the Indian Health Care Improvement Act), and undocumented immigrants.

Penalties for Noncompliance

The consequence for not maintaining insurance for one or more months—for those not exempt from the mandate—would be an excise tax of the greater of $750 per adult in the household or 2 percent of household income, up to a maximum of $2,250 per family. This per-adult penalty would be phased-in. In 2014, the tax would be $95; in 2015, $495; and in 2016, $750. The penalty would be increased annually based on a cost-of-living adjustment beginning after 2016. The penalty for those under age 18 would be one-half the amount for adults. The tax 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.

Medicaid Expansion

The Senate bill would establish 133 percent of poverty as the new mandatory minimum Medicaid eligibility level for all nonelderly individuals (i.e., children, pregnant women, parents, childless adults) beginning on January 1, 2014. Full federal funding would be provided for expansion populations for 2014, 2015, and 2016. Beginning in April 2010, states can opt to expand Medicaid to adults up to 133 percent of poverty and receive current law federal matching funds. Those newly eligible for Medicaid under the expansion would receive a "benchmark" 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 coverage must provide at least essential benefits, plus coverage for prescription drugs and mental health services.

In January 2014, income disregards and asset tests would no longer apply and eligibility for Medicaid would be based on modified gross income as defined in state exchanges, except for certain populations.

States would be required to maintain existing income eligibility levels for all Medicaid populations through 2013 for adults, and through September 30, 2019, for children currently covered by Medicaid or CHIP.

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.

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, if it is deemed cost-effective for the state.

Beginning in 2014, all states would be required to offer Medicaid to all individuals below age 26 who were in foster care for at least six months and have aged out of the foster care system as of the date of enactment of the bill..

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 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 the full amount to cover expansion populations for 2014, 2015, and 2016. Between 2016 and 2019, states will receive a 23 percentage point increase in the CHIP federal match rate, subject to a 100 percent cap. Beginning in 2017, financing of coverage for the newly eligible will be shared by states and the federal government. In 2017, states that already cover adults with incomes over 100 percent of poverty would receive an increase in their FMAP of 30.3 percentage points and states that currently do not would receive an initial increase of 34.3 percentage points. FMAP increases would be adjusted over time so that by 2019 all states will receive an FMAP increase of 32.3 percentage points. States that had already expanded Medicaid to adults with incomes

above 133% of poverty are not eligible for the enhanced federal funding; they will receive a 2.2 percentage point increase in their FMAP for parents and childless adults who are not newly eligible for 2014 through 2019, or a 0.5 percentage point increase in FMAP for 2014 through 2016.

Children's Health Insurance Program

The Senate bill would maintain the current structure of CHIP, which provides health insurance to children in families above Medicaid eligibility levels. The current reauthorization period of CHIP would be extended for two years, through September 30, 2015. States would be required to maintain income eligibility levels for currently eligible children in Medicaid and CHIP, though this would expire in September 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 2016 by 23 percentage points through 2019, subject to a cap of 100 percent. Children who are eligible for CHIP but are unable to enroll because of enrollment caps will be eligible for tax credits to purchase coverage through an exchange.

Employer Shared Responsibility

The Senate bill requires companies with more than 50 full-time employees that do not offer coverage and have at least one worker receiving an exchange tax credit to pay an uncovered worker fee of $750 per full-time employee. Firms with more than 50 full-time employees that offer coverage that is deemed unaffordable or does not meet the minimum benefit standard must pay the lesser of $3,000 for each full-time worker receiving a tax credit or $750 for each full-time worker. All employers with more than 200 full-time employees would be required to automatically enroll new full-time employees in coverage (employees may opt out of coverage). Beginning in 2014, large employers that impose a waiting period before an employee can enroll in coverage would be required to pay $600 for any full-time employee in a waiting period for longer than 60 days.

Employers that offer coverage and contribute to the cost of coverage are required to offer "free choice vouchers" to employees with incomes below 400 percent of poverty to purchase health plans through the exchange. The voucher must be equal to the contribution that the employer would have made to its own plan. Employees qualify if their required contribution under the employer's plan would be between 8 percent and 9.8 percent of their income. Free choice vouchers are excluded from taxation and voucher recipients are not eligible for tax credits.

Exemptions for Small Businesses
Small businesses with 50 or fewer full-time employees would be exempted from the requirement.

Premium Subsidies for Small Businesses
The Senate bill would provide tax credits to qualifying small businesses for a maximum of two years. In Phase 1 (2010–2013), 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 and average wages below $50,000. The full amount of the credit would be available to employers with 10 or fewer full-time employees, or average wages of $25,000, and phases out. In Phase 2 (beginning in 2014), a tax credit up to 50 percent of the employer premium contribution (must be at least 50% of premium) would be available for employers with fewer than 25 employees and average wages below $50,000 that buy plans through the exchange. The full amount of the credit would be available for employers with 10 or fewer full-time employees and average wages below $25,000. The credit phases out for firms with up to 25 employees (at a rate of 6% of base credit percentage for each employee above 10) and average wages of $25,000 to $50,000 (at a rate of 5% for each $1,000 increase of average wages above $25,000).

Tax-exempt organizations would be eligible to receive small business tax credits, though they are somewhat lower: 25 percent of employer contribution to premium in Phase 1 (2010–13), compared with 35 percent for other companies; and 35 percent in Phase 2, beginning in 2014, compared with 50 percent for other companies.

II. DELIVERY SYSTEM REFORM PROVISIONS

Investing in Primary Care

The Senate bill includes a number of provisions that would strengthen the primary care system in the United States. 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.

The Senate bill makes primary care more accessible for Medicare beneficiaries by removing cost-sharing for preventive services and introducing a new comprehensive health risk assessment as part of an annual wellness visit. 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. To encourage states to implement similar changes to Medicaid, the federal government will offer an increased federal medical assistance percentage (FMAP) contribution of 1 percent to cover these services. The bill allows the HHS secretary to modify coverage of preventive services so that it is consistent with ratings given by the U.S. Preventive Services Task Force, saving an estimated $700 million over 10 years.[2] The comprehensive health risk assessment, to identify chronic diseases, modifiable risk factors, and emergency or urgent health needs, would be available to every beneficiary 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. No copayments or deductibles would apply to these services.

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 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.[3] 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 and

[2] Congressional Budget Office, Letter to the Honorable Harry Reid, December 19, 2009. http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf, hereafter referred to as CBO Cost Estimate of HR 3590; Title IV, Subtitle B, Section 4105, Evidence-Based Coverage of Preventive Services in Medicare.

[3] 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.

a two-month extension enacted in December 2009.[4] As a result, the gap between target and actual spending has steadily increased, leading to a 21.2 percent cut in Medicare physician fees scheduled for March 2010. Although earlier versions of the Senate bill included a temporary provision to increase physician fees by 0.5 percent through 2010, the Patient Protection and Affordable Care Act passed by the Senate did not address the SGR. Separate legislation to enact a comprehensive change to the SGR failed in the Senate in fall 2009, but Senate Majority Leader Harry Reid has indicated that the Senate will consider further changes to the SGR in early 2010.[5]

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 of 1.00—that is, every area is treated as though it has at least the average level of input costs. The Senate bill extends this floor through the end of 2010. 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 Senate bill includes the establishment of a Center for Medicare and Medicaid Innovation within CMS, 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.

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[4] Medicare Improvements for Patients and Providers Act (MIPPA), Public Law 110-275. The SGR extension was included in the Department of Defense Appropriations Act, 2010, Public Law 111-118, Section 1011.

[5] S. 1776, the Medicare Physician Fairness Act of 2009, would have modified the physician fee update to have a 0 percent conversion factor in 2010 and subsequent years, and would have stopped the use of the SGR formula in determining physician payment rates under Medicare in future years. A cloture vote to end debate about the bill failed on October 21, 2009, 47–53.

Medical Homes

The Senate bill creates a program to provide states with grants to fund community health teams, which in turn would support the development of medical homes by increasing access to comprehensive, community-based, coordinated care. The care must be patient-centered and coordinated by an integrated team of providers.

The Senate bill also expands upon the existing Medicare medical home demonstration project to allow states the option of permitting Medicaid beneficiaries with two or more chronic conditions, one chronic condition with a risk of a second, or a serious and persistent mental health condition to designate a provider as a medical home. 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. The program would be evaluated in 2017 for its impact on reducing hospital admissions, emergency room visits, and skilled nursing facility admissions.

Accountable Care Organizations

The Senate bill allows eligible providers to be recognized as accountable care organizations (ACOs) and to share in the savings they produce for Medicare. To qualify as an ACO, groups must include providers and suppliers who 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 measures, 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 meets certain quality-of-care targets and reduces costs 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 Senate bill, the HHS secretary would be required to develop a national, voluntary pilot program that is designed to encourage hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models spanning three days before and 30 days after a hospitalization. The bill requires the HHS secretary to establish this program by January 1, 2013, for a period of five years. 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 in 2016 to Congress on making the pilot a permanent part of the Medicare program.

In addition, the bill reduces payments for hospitals based on each hospital's percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by the National Quality Forum. The bill provides HHS authority to expand the policy to additional conditions in future years and directs the secretary to calculate and make publicly available information on all patient hospital readmission rates for certain conditions

In addition, the Senate bill requires CMS to establish a three-year pilot program in Medicare, the Community-based 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 Senate bill establishes a new Independent Payment Advisory Board to submit proposals to Congress that would extend Medicare solvency, slow Medicare cost growth, and increase quality of care. The recommendations provided by the new Medicare Advisory Board would be considered binding unless the Senate votes with a three-fifths 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 a requirement 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. Pilot programs would be created to test new payment models in the Medicare and Medicaid programs, including bundled payments, and would be expanded if they improve quality and reduce costs. Provider payments would be modified by reducing market basket updates 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.

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 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 annually.

To ensure that lessons learned are shared among all health care government sectors, the president would convene an interagency working group on health care quality 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 quality initiatives under the national strategy.

In addition, the bill calls on the secretary, in conjunction with the directors of AHRQ and CMS, to identify quality measures that should be developed or enhanced. The quality measures should assess health outcomes, management and coordination of health care, patient experience, use of health information technology, patient safety, efficiency of care, and other areas deemed appropriate by the secretary. 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 from 2010 to 2014.

The Senate bill requires the secretary to apply a separate, budget-neutral payment modifier to the physician fee schedule under Medicare. 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 provide information to physicians about the value of the care they provide by 2014. 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 improve research, the Center for Quality Improvement and Patient Safety within AHRQ would be expanded. In addition to overseeing research, this organization

would offer local health care providers implementation and technical assistance to teach and implement best practices. Local providers also would be eligible for grants to implement medication management services.

To ensure that quality measures are reported and used effectively to improve care, the Senate 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. In addition, the bill requires the secretary to develop a Physician Compare Web site where Medicare beneficiaries can compare scientifically sound measures of physician quality and patient experiences.

Comparative Effectiveness

The Senate bill 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, and the bill contains patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality-of-life preference. 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 to 2019.

Savings from Delivery System Reforms

More than half of the net cost of coverage expansion in the Senate bill would be offset by savings from changes to the health care delivery system as described above. CBO estimates that provisions in the Senate bill intended to make Medicare and Medicaid more efficient would yield a net $483 billion in federal savings over 2010 to 2019.

Provider Payment Changes and Productivity Update

The Senate bill would hold increases in payment rates for all nonphysician providers below the rate of inflation to account for expected ongoing productivity improvements, and would adjust some provider payment rates to compensate for historical overpayment.[6] These market basket cuts are estimated to yield $151 billion in savings over 10 years.

Medicare Advantage Reforms

The Senate 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 $136 billion in savings over 10 years.[7]

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 Senate 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 $43 billion in savings through 2019.[8]

Independent Payment Advisory Board

The Senate bill would establish a 15-member, Independent Payment Advisory Board to present Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. The Board would be required to submit proposals to Congress on years in which Medicare costs are projected to be unsustainable. The Board's proposals to Congress would extend Medicare solvency, improve quality of care, and reduce excess cost growth by 0.5 percent in 2015. The

[6] CBO Cost Estimate of HR 3590; Title III, Subtitle B, Part III, Sections 3135 and 3136; and Title III, Subtitle E, Section 3401.

[7] CBO Cost Estimate of HR 3590; Title III, Subtitle C (Provisions Relating to Part C), Sections 3201-3210; and Medicare Advantage Interactions.

[8] CBO Cost Estimate of HR 3590; Title II, Subtitle G (Medicaid Disproportionate Share Hospital Payments); and Title III, Subtitle B, Part III, Section 3133.

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 and beyond. Recommendations by the Board would automatically go into effect unless blocked by subsequent legislation. CBO estimates that the Board would yield $28 billion in savings from 2010 to 2019.[9]

Innovative Payment Methods

A number of innovative provider payment methods are included in the Senate bill in an effort to better link payment to quality outcomes in Medicare, including hospital value-based purchasing; the physician quality reporting initiative; improvements to 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 $8 billion in savings over 10 years.[10]

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. In addition to rebasing home health payments starting in 2014, the Senate bill would implement a 10 percent provider-specific cap on home health outlier payments, and would reinstate add-on payments for rural providers to ensure access to care and quality services, resulting in $39 billion in savings over 10 years.[11]

Reducing Hospital Readmissions

Under the Senate bill, starting in 2012, hospitals with readmission rates above a certain threshold would face reduced reimbursements for three conditions with risk-adjusted admission measures currently endorsed by the National Quality Forum.[12] CBO estimates that this provision would yield $7 billion in savings from 2010 to 2019.[13]

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[9] CBO Cost Estimate of HR 3590; Title III, Subtitle E, Section 3403.

[10] CBO Cost Estimate of HR 3590; Title III, Subtitle A, Part I (Linking Payment to Quality Outcomes Under the Medicare Program); and Title III, Subtitle A, Part III, Sections 3021 and 3022.

[11] CBO Cost Estimate of HR 3590; Title III, Subtitle B, Part III, Section 3131.

[12] The policy could be expanded to additional conditions in future years as determined by the Secretary of Health and Human Services based on spending and readmission rates.

[13] CBO Cost Estimate of HR 3590; Title III, Subtitle A, Part III, Section 3025.

Primary Care

To strengthen the primary care workforce, the Senate bill would provide a primary care/general surgery bonus, invest in graduate medical education for those interested in a career in primary care, and improve and expand federally qualified health centers. These provisions would cost an estimated $6 billion from 2010 to 2019.[14]

Prescription Drug Payment Rate Changes

The Senate 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 under Medicare or 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 $6 billion over 10 years.[15]

Other Improvements and Interactions Between Reforms

The Senate 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, would yield an estimated $83 billion in savings from 2010 to 2019.[16]

Increased Revenues

Along with the system savings described above, new revenues outlined in the Senate bill more than outweigh the cost of expanding and improving coverage. The Joint Committee on Taxation estimates that the Senate bill would produce $413 billion in new revenues from 2010 to 2019. Of that amount, $264 billion would come from provisions modifying flexible spending and health savings accounts; new annual fees on manufacturers and

[14] CBO Cost Estimate of HR 3590; Title V, Subtitle F (Strengthening Primary Care and Other Workforce Improvements), Sections 5501–5509.

[15] CBO Cost Estimate of HR 3590; Title III, Subtitle D (Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans), Sections 3301–3315; and Title VI, Subtitle A, Sections 6004–6005.

[16] CBO Cost Estimate of HR 3590.

importers of drugs and devices and on health insurance providers; and changes to some tax deductions.[17] 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 $149 billion in increased revenues over 10 years. For policies that cost in excess of $8,500 for an individual and $23,000 for a family, a 40 percent excise tax would be applied to the insurers writing the policy beginning in 2013.

The premium threshold would be indexed to the consumer price index plus 1 percentage point in 2014 and beyond; this increase would be slower than the rate of health care cost growth, resulting in an annual increase in the number of people with plans that exceed the threshold unless health care cost growth slows substantially. For retired individuals over age 55 with employer-sponsored coverage, the threshold is increased to $9,850 for individuals and $26,000 for family coverage. In addition, employees that are engaged in high-risk professions are also eligible for 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; the threshold amounts would be 20 percent, 10 percent, and 5 percent higher in the first three years, respectively.

[17] "Estimated Revenue Effects Of The Revenue Provisions Contained In the 'Patient Protection and Affordable Care Act'," Joint Committee on Taxation, December 19, 2009, JCX-61-09, http://jct.gov/publications.html?func=startdown&id=3641.